



PRESIDENT'S TASK FORCE TO

Improve Health Care Delivery For Our Nation's Veterans

Final Report 2003



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For Our Nation's Veterans

FINAL REPORT

MAY 2003



President's Task Force To Improve
Health Care Delivery For Our Nation's Veterans

May 26, 2003

The President
The White House
Washington, DC 20500

Dear Mr. President:

We take great pleasure in presenting this *Final Report* of the President's Task Force to Improve Health Care Delivery for Our Nation's Veterans. This report is submitted in accordance with the provisions of Executive Order 13214, dated May 28, 2001, and is dedicated to the memory of former Congressman Gerald B. Solomon, an original Task Force Co-Chair, a genuine patriot, and a staunch advocate for veterans.

As cited in our *Interim Report*, the Task Force was created to recommend bold, practical, and specific reforms in the delivery of health care to beneficiaries of the Department of Veterans Affairs and the Department of Defense. This report reflects the collective thinking of 15 Members with a wide diversity of viewpoints on how to improve beneficiary health care delivery. Task Force Members share a common desire to identify and address barriers to collaborative efforts between the Departments and offer this report as an alternative to the status quo in veterans' health care. The Task Force believes the recommendations in this report represent strategies for use in addressing barriers to collaboration and, when implemented, will complement and enhance your management agenda for VA and DOD.

As we submit this report, we express our appreciation for the cooperation and openness displayed by leaders and employees in both Departments, and in numerous field activities around the Nation. Many dedicated and enthusiastic people in VA and DOD have helped shape our findings and recommendations. Additionally, we have received great support from veterans' service organizations and military advocacy groups. We sincerely hope our recommendations will facilitate ongoing efforts to enhance the delivery of health care for our Nation's veterans.

Respectfully:

A handwritten signature in black ink, reading "Gail R. Wilensky".

GAIL R. WILENSKY, Ph.D.
Co-Chair

A handwritten signature in black ink, reading "John Paul Hammerschmidt".

JOHN PAUL HAMMERSCHMIDT
U.S. Congress, 1967-1993
Co-Chair

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Gerald Brooks Hunt Solomon

August 14, 1930 – October 26, 2001

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Executive Summary

EXECUTIVE SUMMARY

In May 2001, President George W. Bush signed Executive Order 13214 creating the President's Task Force (PTF) to Improve Health Care Delivery for Our Nation's Veterans. The charge to the Task Force was to identify ways to improve health care delivery to Department of Veterans Affairs (VA) and Department of Defense (DOD) beneficiaries through better coordination and improved business practices.

For more than two decades, there have been numerous efforts by Congress and the Executive Branch aimed at increasing collaboration and sharing between the two Departments in order to improve the efficiency and cost effectiveness of health care delivery for beneficiaries. Providing all enrolled veterans, including military retirees, with timely access to the full range of health benefits earned through service to their country is a national obligation, whether during their military service or once they have achieved veteran status.

As the Task Force visited numerous VA and DOD health care facilities around the country, conducted focus groups with individual beneficiaries, and met with many beneficiary organizations, it became clear that the current mismatch in VA between demand and available funding not only impedes collaboration efforts with DOD but that, if unresolved, the resultant delay in veterans' access to care could threaten the quality of VA health care.

Although enrolled veterans technically have access to the VA health care system, long waiting times for appointments with health care providers continue to be problematic for a significant number of veterans. As of January 2003, at least 236,000 veterans were on a waiting list of six months or more for a first appointment or an initial follow-up—a clear indication of lack of sufficient capacity or, at a minimum, a lack of adequate resources to provide the required care. While the overall number of veterans eligible for care in VA facilities is expected to decrease over the coming years, the actual number of beneficiaries seeking VA care is projected to increase because of factors outside of VA.

A confluence of events over the past decade—economic, budgetary, and structural—has created increased demands for, and pressures on, the VA and DOD health care systems. With the rising cost of health care and insurance premiums, veterans have been seeking alternative ways to pay for their health care. This phenomenon, along with the absence of an outpatient

pharmacy benefit under Medicare, appears to be causing significant numbers of veterans to seek health care from VA.

Finally, legislative, administrative, and structural changes have increased demand for VA care. Following the passage of the Veterans' Health Care Eligibility Reform Act of 1996, VA's mission moved from primarily treating veterans with service-connected disabilities and indigent veterans to offering a comprehensive health benefit to all enrolled veterans. The Veterans' Millennium Health Care and Benefits Act, enacted in 1999, further increased demand by expanding benefits. Funding provided through the current budget and appropriations process for VA health care delivery has not kept pace with demand, despite efforts to increase efficiencies and focus health care delivery in the most cost-effective manner.

Organizing Principles

In developing this report, the Task Force established four principles on which to organize its analyses and recommendations:

1. Committed leadership is essential to achieve VA/DOD collaboration to improve health care to veterans, including military retirees.
2. To provide timely, high-quality care, it is important to have seamless transition of information across the full lifecycle of health care for each veteran, especially at the point when he or she moves from military service to veteran or retiree status.
3. VA and DOD collaboration can improve quality, access, and efficiency of health care delivery by pooling resources, eliminating administrative barriers, and implementing change.
4. Despite the importance of collaboration in overcoming modest or temporary capacity shortfalls or surges in demand, the mismatch in VA between demand for access and available funding is too large to be solved by collaboration alone. Thus, the only effective way to address the growing problem of access in VA is to reduce the apparent mismatch between demand and funding.

Leadership

The Task Force is pleased with the current VA/DOD efforts on collaboration and sharing and with the organizational structures created to facilitate such efforts. Senior leadership of the Departments are clearly engaged, especially through the interagency leadership

committee. It is the responsibility of the leadership of the two Departments, starting with the Secretaries, to continue to demand actions that will ensure the success of VA/DOD collaboration.

VA and DOD leadership need to clearly and jointly articulate what is expected as the end state of collaboration and sharing. The goal is not collaboration for mere collaboration's sake, but rather, through such activity, to improve access to care and reduce the overall cost of furnishing services. There can be no ambiguity in the description of clear and measurable goals for improved cooperation.

Once those in leadership positions have communicated their directives, the Departments should issue plans in a timely manner, including performance expectations, measurements, and time lines. These plans should be communicated in a consistent manner to all levels of the two Departments and should be regularly reviewed for outcomes. To foster ongoing accountability, there should be an annual report from the interagency leadership committee to the Secretaries on the results of performance in the area of collaboration and sharing and next year's goals, including progress in implementing the recommendations in this report.

Seamless Transition to Veteran Status

VA and DOD responsibility for an individual's health begins as soon as the individual enters the Armed Forces. An important first step would be to gather baseline medical information upon entry into the military and capture it in an electronic medical record that would, at a later point, be able to readily and easily exchange appropriate health information with VA in mutually understood and usable formats. As no such capability exists today, the two Departments must collaboratively develop appropriate electronic medical records that can function in an interoperable, bi-directional manner.

During military service, information relevant to a service member's deployments, occupational exposures, and health conditions should follow the service member through his or her military career. Better recording, tracking, and reporting of occupational health data will improve the research base for understanding the etiology of service-related disorders, assist in benefits determinations, and improve the overall health of today's veterans as well as those who will follow them.

Once an individual separates from military service, the process for determining eligibility for veterans' benefits, assessing health status, and receiving care through the VA health care system should be seamless, timely, and accurate. These goals can only be accomplished through systems that are standards-based and coordinated between

VA and DOD. When an individual is separated from military service, he or she is issued a DD214, which is needed to access health care services in the VA system. VA has identified untimely access to the service member's DD214 as a major factor delaying determination of benefits. To ease the transition from service member to veteran status, VA and DOD should:

- implement by fiscal year 2005 a mandatory single separation physical as a prerequisite of promptly completing the military separation process; and
- expand the "one-stop shopping" process to include, at a minimum, a standard discharge exam, full outreach, claimant counseling, and when appropriate, referral for a VA Compensation and Pension examination and follow-up claims adjudication and rating. Upon a service member's separation, DOD should transmit an electronic DD214 to VA.

Both VA and DOD will continue to face significant issues in dealing with veterans who develop health conditions as a result of possible occupational exposures and hazards during military service. VA and DOD should:

- expand their collaboration to identify, collect, and maintain data needed to:
 - 1) recognize, treat, and prevent illness and injury resulting from occupational exposures and hazards experienced while serving in the Armed Forces; and
 - 2) conduct epidemiological studies to understand the consequences of occupational exposures and hazards;
- by fiscal year 2004, initiate a process for routine sharing of each service member's assignment history, exposures to occupational hazards, location, and injuries information; and
- jointly issue a publicly available annual report on Force Health Protection.

In addition, the President should direct VA and DOD to implement continuous health surveillance and research programs to identify the long-term health consequences of military service in high-risk occupations, settings, or events.

Removing Barriers to VA/DOD Collaboration

Significant institutional barriers to collaboration arise from the ways VA and DOD—and the three Military Departments—develop and deploy their resource plans. These include the budgeting process, health care delivery plans, acquisition plans, and facility plans.

The PTF makes a series of recommendations to remove barriers and improve collaboration, including:

- revise health care organizational structures to provide more effective and coordinated management of the two health care systems, enhance overall health care outcomes, and improve structural congruence;
- integrate clinical pharmacy initiatives through the coordinated development of a national joint core formulary and a single, common clinical screening tool by fiscal year 2005;
- work with industry to establish a uniform methodology for medical supplies and equipment identification and standardization in order to facilitate additional joint contracting initiatives;
- identify functional areas where the Departments have similar information requirements in order to re-engineer, where necessary, business processes and develop the specific functional information technology requirements needed to support them;
- implement facility lifecycle management practices on an enterprise-wide basis;
- declare that joint ventures are integral to the standard operations of both Departments and use the existing joint venture organizations as laboratories for developing future inter-departmental policy frameworks; and
- work together to identify and address staffing shortfalls, develop consistent clinical scopes of practice for non-physician providers, and ensure that the two provider credentialing systems can interface.

Eliminating the Mismatch Between Demand and Funding

Although the measures described above might help staff and facilities in some areas overcome modest or temporary capacity shortfalls or surges in demand, and standardization and compatibility of information systems and medical records between VA and DOD will provide lasting improvements in health care delivery to veterans, the apparent mismatch in VA between demand for access and available funding is too large to be solved by collaboration alone. The PTF is concerned that this mismatch affects the delivery of timely health care and impedes efforts to improve collaboration between VA and DOD.

In recent years, because of the entrance of veterans with income levels above VA's means test threshold with no compensable service-related disabilities (former Priority Group 7) into the VA health care system, and with funding not keeping pace with demand, many veterans in VA's traditional constituency, those veterans with service-connected disabilities and indigent veterans (Priority Groups 1 through 6), have been unable to obtain health care within VA's established access time frames. This situation is unacceptable.

The PTF developed recommendations in two separate but inextricably related areas: funding delivery of care within the access standard for Priority Groups 1 through 7 (new) and the need to clarify eligibility and benefits for Priority Group 8.

Congress and the Executive Branch must work together to provide full funding to meet demand, within VA's access standards, for Priority Groups 1 through 7 (new). The Task Force offers examples for consideration to modify the process used to fund health care delivery for these veterans. The Task Force also recommends that VA be accountable for meeting its established access standards; when appointments cannot be offered within the standard, the Department should be required to offer an enrolled veteran an appointment with a non-VA provider.

The Congress and the Executive Branch must resolve the status of veterans with income levels above VA's means test threshold with no compensable service-related disabilities (Priority Group 8).

For many years, there has been little disagreement on the need to improve collaboration and sharing between the two Departments. The structures needed to organize and implement collaboration and sharing are now in place, and current leadership has demonstrated a commitment to furthering this goal. What is needed is the will and focus to implement and sustain change.

C H A P T E R O N E

Introduction & Background

CHAPTER ONE

Introduction and Background

Past Congresses and Presidents have honored the service and sacrifice of those who served in our Nation's Armed Forces by enacting legislation to provide military personnel and eligible veterans with access to quality health care. As a result of sustained federal support, the Departments of Veterans Affairs (VA) and Defense (DOD) have grown to become two giants in the health care industry. With combined annual health care budgets of nearly \$50 billion, they offer care at a total of more than 1,600 sites nationwide. There are over 300,000 personnel in both systems, treating nearly 12 million beneficiaries. Both systems face the challenges of health care systems everywhere—new practices, techniques, and tools, changing demographics, aging infrastructure, and increasing costs. At the same time, access to health care is a growing concern for many Americans, and the health services provided through VA and DOD to beneficiaries are an increasingly important resource. Indeed, for some veterans, VA may be their only health care option.

All veterans, whether injured in military service or not, deserve clarity and fairness in the policies and practices related to benefits received following their service to the Nation. However, these individuals have not always been treated fairly, equitably, or appropriately when seeking access to health care. Eligibility requirements have changed over time, as have benefits. And, although enrolled veterans theoretically have access to the VA health care system, in reality long waiting times for appointments with health care providers continue to be an impediment for a significant number of enrollees. As of January 1, 2003, over 236,000 enrolled veterans were on waiting lists of more than six months for a first appointment or for an initial follow-up for health care from VA—a clear indication of lack of sufficient capacity or, at a minimum, a lack of adequate resources to provide the required care.

As of January 1, 2003, over 236,000 enrolled veterans were on waiting lists of more than six months for a first appointment or for an initial follow-up for health care from VA.

The overall number of veterans eligible for care in VA facilities is expected to decrease over the coming years. However, the actual number of beneficiaries seeking VA care has grown, and increased demand on the system is projected to continue. Specifically, since 1999, the number of VA enrollees has increased nearly 20 percent annually, from 4 million enrollees to an enrollment of 6.3 million in 2003. Based on VA's projection model, without any limitation on enrollment, that growth will continue, with enrollment peaking in fiscal year 2012 at approximately 8.9 million enrollees. While enrollments are increasing in all priority groups, Priority Group 8 (see Appendix F for a description of Priority Groups) is experiencing the largest and fastest growth: by fiscal year 2012, VA projects that veterans in this group will constitute 27 percent of all enrollees.¹ An additional trend affecting future costs of care is the aging of the veteran population. The growth in the elderly veteran population, combined with their heavy use of pharmaceuticals—which are also consuming greater shares of the health care dollar—foretells rising costs of care.

In addition, a confluence of events over the past decade—economic, budgetary, and structural—has created increased demands for, and pressures on, the VA and DOD health care systems. With the rising cost of health care and insurance premiums, veterans have been seeking alternative ways to pay for their health care. This phenomenon, along with the absence of an outpatient pharmacy benefit under Medicare, appears to be causing significant numbers of veterans to seek health care from VA. Finally, during the past decade, public and private sector health care has shifted significantly from inpatient to outpatient care; treatment protocols increasingly rely on new and costly technologies; and the use of pharmaceuticals has dramatically increased in both prevention and treatment of illnesses. These forces have placed tremendous strains on both public and private sector health care.

Legislative, administrative, and structural changes at VA have also increased demand. Following the passage of the Veterans' Health Care Eligibility Reform Act of 1996 (Public Law 104-262), VA's mission moved from primarily treating veterans with service-connected disabilities and indigent veterans to offering a comprehensive health benefit to all enrolled veterans. The Veterans' Millennium Health Care and Benefits Act (Public Law 106-117), enacted in 1999, further increased demand by expanding eligibility for home-based and long-term care. In addition, by eliminating barriers to access (particularly to primary care) through the creation of over 600 new Community-Based Outpatient Clinics, VA has been extremely effective in attracting additional veterans to the system, thereby increasing demand. However, the funding provided through the current budget and appropriations process for VA health care delivery has not kept pace with demand, despite efforts to increase efficiencies and deliver health care in the most cost-effective manner.

¹ Effective January 17, 2003, VA stopped enrolling Priority Group 8 veterans.

Recurring Themes

Enrolled veterans and military retirees should have full and timely access to the health care services that Congress has authorized for them. Various approaches to fulfilling this obligation have been suggested, including better collaboration and sharing between VA and DOD, improved processes for transition from military service to veteran status, and enhanced funding. A number of commissions, advisory panels, and government study groups convened since 1991 have looked at these issues and provided recommendations.

In 1991, the Report of the Commission on the Future Structure of Veterans Health Care made recommendations in four fundamental areas: 1) improving access; 2) financing the future; 3) restructuring the system; and 4) enhancing quality of care.

In 1998, the Healthcare Advisory Group Report to the Congressional Commission on Service Members and Veterans Transition Assistance (the Transition Commission), recommended that VA and DOD health care sharing be enhanced through:

- legislation allowing beneficiary care in either system and corresponding reimbursement;
- a congressional commission to review the health care delivery systems of both Departments, on a geographic basis, including the availability of joint operations and the physical infrastructure/capacity of the two systems; and
- legislation requiring DOD to recognize appropriate VA Medical Centers as military treatment facility equivalents when the local VA facility could treat TRICARE patients at or below the cost of non-governmental providers in the local community.

In its final report, the Transition Commission proposed “fundamental and far-reaching” reforms to VA and DOD programs and organization, urging the Departments to develop closer partnerships or risk failure in their health care missions. The report observed that benefits and services as well as program management of the two systems were “so ineffective they break faith with those who served, and currently serve, their Nation in uniform.” It argued that although “senior leadership in both Departments support the principle of sharing, day to day decisions are the product of separate staffs working independently, without taking into account the needs or resources of the other Department.” In addition, the Commission concluded that

The Transition Commission proposed “fundamental and far-reaching” reforms to VA and DOD programs and organization, urging the Departments to develop closer partnerships or risk failure in their health care missions.

“neither system can be sustained as it is in the current budget climate and that, although the two systems have made great strides in establishing a cooperative relationship, they must move toward an even closer partnership if they are to continue to succeed in their missions.”

In 2001, Eagle Group International, Inc., submitted an *Independent Assessment of Department of Veterans Affairs and Department of Defense Sharing Agreements and Program* to the Director, Special Programs Division of the TRICARE Management Activity. Recommendations were made to reduce the unnecessary outflow of federal funds, simplify the current environment for sharing opportunities, and optimize targets of opportunity.

In addition, numerous General Accounting Office (GAO) reviews have encouraged the Departments to pursue cost-effective resource sharing. GAO reports issued in 2000 and 2001, referenced in Chapter 4, described the benefits of sharing in terms of financial savings and qualitative gains. In its 2000 report, *Evolving Health Care Systems Require Rethinking of Resource Sharing Strategies*, GAO concluded that it may be necessary for Congress to provide specific guidance to both VA and DOD, clarifying the criteria, conditions, and expectations for VA/DOD collaboration.

Thus, the PTF effort and this report build on a long line of prior efforts. But in spite of the extensive research and efforts to increase VA/DOD sharing and collaboration, and thereby improve veterans' access to care, the results until very recently have been at best marginal, or at worst, superficial.

President's Task Force To Improve Health Care Delivery For Our Nation's Veterans

President George W. Bush identified “improved cooperation between the Department of Defense and Department of Veterans Affairs in providing care to those who served” as one of ten management improvements for his Administration. On May 28, 2001, he signed Executive Order 13214 creating the President's Task Force to Improve Health Care Delivery for Our Nation's Veterans (hereafter referred to as the PTF). In subsequent speeches, the President described his desire for “major reforms” in the delivery of health care provided by the two Departments. To that end, Executive Order 13214 directed the Task Force to:

- 1 identify ways to improve benefits and services for Department of Veterans Affairs beneficiaries and Department of Defense military retirees who are also eligible for benefits from the Department of Veterans Affairs through better coordination of the activities of the two Departments;

- 2 review barriers and challenges that impede Department of Veterans Affairs and Department of Defense coordination, including budgeting processes, timely billing, cost accounting, information technology, and reimbursement. Identify opportunities to improve such business practices to ensure high-quality and cost-effective health care; and
- 3 identify opportunities for improved resource utilization through partnership between the Department of Veterans Affairs and the Department of Defense to maximize the use of resources and infrastructure, including buildings, information technology and data sharing systems, procurement of supplies, equipment and services, and delivery of care.

The PTF is comprised of 15 Members appointed by the President, including two Co-Chairs. The Co-Chairs appointed an Executive Director to coordinate administration of the PTF through a professional staff. Based on the requirements in the Executive Order and VA Charter establishing administrative support and funding, the PTF submitted an *Interim Report* in July 2002.² This *Final Report* reflects the PTF Members' commitment to accomplishing the missions outlined in the Executive Order.

Organizing Principles

The PTF established four central principles on which to organize its analyses and recommendations:

- 1 Committed leadership is essential to achieve VA/DOD collaboration to improve health care delivery to veterans.
- 2 To provide timely, high-quality care, it is important to have seamless transition of information across the full lifecycle of health care for each veteran, especially at the point when he or she moves from military service to veteran or retiree status.
- 3 VA and DOD collaboration can improve quality, access, and efficiency of health care delivery by pooling resources, eliminating administrative barriers, and implementing change.
- 4 Despite the importance of collaboration in overcoming modest or temporary capacity shortfalls or surges in demand, the apparent mismatch in VA between demand for access and available funding is too large to be solved by collaboration alone. Thus, the only effective way to address the growing problem of access in VA is to reduce the mismatch.

² The *Interim Report* is available at www.presidentshhealthcare.org until September 2003, when it will be available through the Department of Veterans Affairs website (home page www.va.gov).

Leadership, Collaboration, and Oversight

The PTF believes that greater VA/DOD collaboration and sharing will improve the efficiency of, and veterans' timely access to, health care delivery in both Departments. Sharing authority for the two Departments was legislated in 1982, and Congress has continued to encourage and support the concept. However, until recently, the extent of sharing and collaboration between the two Departments has been disappointing. Congress continues to urge the Secretaries of Defense and Veterans Affairs to commit their Departments to significantly improve mutually beneficial sharing and coordination of health care resources. To that end, the PTF emphasizes

the need to build organizational cultures and enduring leadership that support improved sharing and coordination of health care resources and services.

Leaders must establish organizational cultures and mechanisms that support collaboration, improve sharing, and coordinate the management and oversight of health care resources and services, with clear accountability for results.

At present, there appears to be a strong interest in both Departments in moving forward on collaboration; however, history shows that such interest has varied over time. To institutionalize a collaborative and sharing relationship that transcends leadership changes, there must be clear commitment from top leadership. These leaders must establish organizational cultures and mechanisms that support collaboration, improve sharing, and coordinate the management and oversight

of health care resources and services, with clear accountability for results. Chapter 2 focuses on this area and provides recommendations for further improvement.

Seamless Transition to Veteran Status

Once an individual transitions from military service to veteran status, if eligible for VA health benefits, he or she must learn the rules and limits of an entirely different health care system. While in the military, service members and their families are enrolled in DOD's TRICARE program, in which individuals can receive care at DOD facilities or approved private providers, which include VA facilities. Individuals leaving service with service-connected injuries or illnesses are most likely to seek care from the VA health care system, and are thus most likely to need a full range of transition assistance. However, most individuals completing their service do not have immediate health care needs and may not participate in all available separation processes, such as separation physical examinations.

Those veterans who later seek VA health care may find the process for gaining entry into the system frustrating and time-consuming. Chapter 3 provides recommendations to

VA and DOD to promote a seamless transition. One central recommendation is to develop a system in which information flows easily across all components of care, geographic sites, and discrete patient-care incidents while protecting privacy and confidentiality. Such sharing of information would also provide VA and DOD with insights about disease or illnesses that could result from exposure to occupational hazards during military service, and assist in epidemiological research.

Collaboration, Resource Sharing, and Standardization

VA and DOD continuously—but separately—refine and improve their health care delivery systems. As a result, the two systems have developed diverse and sometimes contradictory solutions for similar problems, with a potential for increased overall cost and decreased efficiency. Many differences exist between the two Departments in personnel management, training programs, facilities, infrastructure, information management and technology (IM/IT), and acquisition programs that do not appear to be driven by their differing missions. The incompatibility of the Departments' statutory and corporate business rules significantly impedes meaningful collaboration.

This incompatibility is readily apparent when one considers the tenuous progress made at seven sites, known as joint ventures, created by the Departments. These sites have operated largely in an ad hoc manner, as discussed in Chapter 4, but offer excellent opportunities as “laboratories” for formal collaboration policy framework development.

Without question, the two Departments have separate functions driven by their core missions that should remain distinct and freestanding. However, other functions are prime candidates for the development of common standards, creation of interoperable and interchangeable program elements, and joint development and operation of functional elements in the name of increased efficiency, cost avoidance, and improved access for beneficiaries.

In joint pharmacy procurement, VA and DOD have made significant progress. But in other areas, such as purchasing services from each other, there has been little sustained progress. Collaboration has been impeded by the lack of a joint strategic planning effort to develop common objectives for interdepartmental partnering. Progress toward joint strategic planning is underway, however, under the auspices of the interagency leadership committee (discussed in Chapter 2). Consistent with these nascent strategic planning efforts, the Departments need to:

- develop a coordinated budget and execution strategy for collaboration;
- eliminate policy and program barriers between VA and DOD; and
- institutionalize processes that ensure collaboration and communication.

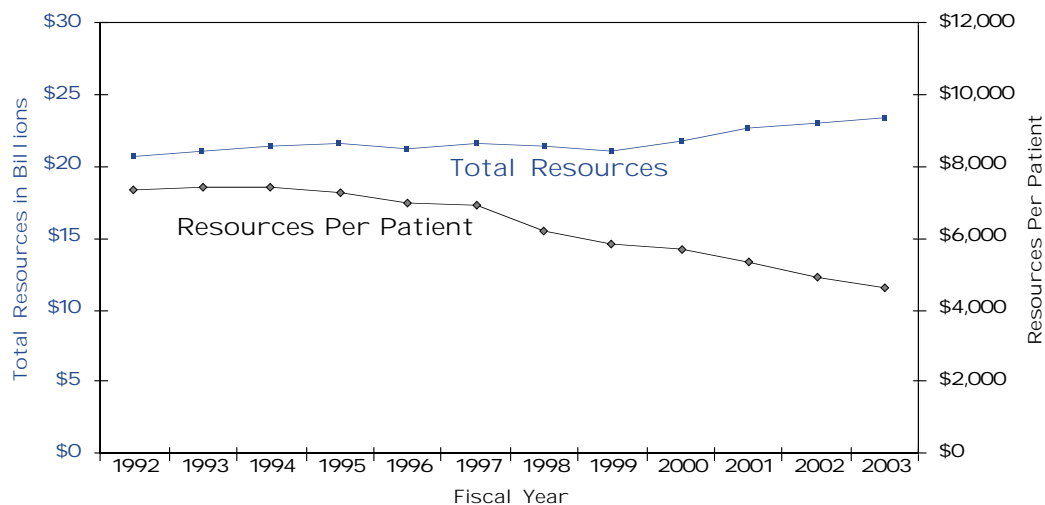
Chapter 4 identifies some barriers to collaboration, discusses various approaches for advancing collaboration, and makes recommendations for change.

Access to Health Care Services and the Mismatch between Demand and Funding

Chapters 3 and 4 of this report focus on ways to increase collaborative efforts between the VA and DOD systems and on the need for productivity improvements. Despite the importance of these efforts, it became apparent to the PTF that increased collaboration could not effectively address access issues because neither system has significant excess capacity. Collaboration might help facilities in some areas overcome modest or temporary capacity shortfalls or surges in demand. However, the persistent disparity between demand and funding in VA significantly inhibits effective collaboration arrangements and the delivery of health care itself. The apparent mismatch between demand for access and available VA funding is too large to be solved by collaboration alone.

To its credit, VA has managed to cope within constrained resources over time by becoming a more efficient provider of care (see Figure 1.1). This achievement results partly from VA's focus on delivering care in the most cost-effective manner, such as moving from inpatient to outpatient care. But more to the point, increasing enrollee demand, combined with available funding, has forced significant reductions in per-patient expenditures beyond what could be expected from improved efficiency. Based on their findings, PTF Members believe that even if VA were operating at maximum efficiency, it would be unable to meet its obligations to enrolled veterans with its current level of funding. A more focused and concerted effort must be made to bring funding and demand into balance.

Figure 1.1 VA's Declining Per-Patient Expenditures, FY 1992-2003*
(Expressed in FY 2002 Dollar Terms)



*All resources, including collections

Chapter 5 provides the PTF's assessment of the access problems encountered by enrolled veterans, describes how evolutionary changes in VA's mission have affected access and demand, and how current methods of funding the VA health benefit further contribute to the problem. The chapter provides specific recommendations to clarify veterans' health care eligibility and reduce the mismatch of funding to support that care.

The PTF's Vision

The PTF envisions a VA health care system that is no longer impaired by the mismatch between resources and demand, working collaboratively with the DOD health care system to increase the accessibility and quality of health care for enrolled veterans, including military retirees. This vision is grounded in the recognition of the Nation's obligation to those who have served this country and the belief that improved coordination and cooperation between the VA and DOD health care delivery systems will provide continuing opportunities for meeting this obligation.

The PTF believes that outstanding health care delivery for our Nation's veterans and military beneficiaries occurs when VA, DOD, civilian, and other organizations maximize the delivery of high-quality care to all enrollees. This would be accomplished through a system that:

- is easily accessible and coordinated among all organizations;
- focuses on cost-effective treatment and prevention;
- delivers care through the home and workplace, as well as traditional health care settings;
- leverages best practices across organizations; and
- stimulates innovation, accountability, productivity, and continuous improvement within VA and DOD.

For many years, there has been little disagreement on the need to improve coordination and sharing across the two Departments. The structures needed to organize and implement collaboration and sharing are now in place, and current leadership has demonstrated a commitment to furthering this goal. What is needed is the will and focus to implement and sustain substantive change.

To maintain the momentum achieved to date—and to foster ongoing accountability—the PTF believes that there should be an annual report on the progress of the two Departments in implementing their collaboration and sharing initiatives and the recommendations in this report.

Recommendation 1.1

The interagency leadership committee should, on an annual basis, report to the Secretaries on the status of implementing its collaboration and sharing initiatives and the recommendations in this Final Report, together with any other matters that the committee deems appropriate. Within 60 days after receipt, the Secretaries shall transmit the report, together with any related comments, to the President.

CHAPTER TWO

The Need for Leadership, Collaboration, and Oversight

CHAPTER TWO

The Need for Leadership, Collaboration, and Oversight

For over 20 years, members of Congress and others have urged the Departments of Veterans Affairs and Defense to increase collaboration and sharing, especially in the area of health care, and to work at eliminating the barriers to coordination. Initially, the obstacles to greater coordination were statutory, but that changed with the enactment in 1982 of the Veterans Administration and Department of Defense Health Resources Sharing and Emergency Operations Act (Public Law 97-174, hereinafter the “Sharing Act”).

The Sharing Act was intended to make it easier for the two Departments to increase the variety and amount of health resource sharing for the benefit of their veteran and military beneficiaries, while helping hold down costs.

From the outset, there was recognition that there must be senior level leadership in both Departments charged with promoting increased collaboration. This recognition is reflected in subsection (b) of section 8111 of title 38, U.S. Code, as added by the Sharing Act, which mandated the establishment of an interagency senior leadership committee, chaired by VA’s Under Secretary for Health and the Assistant Secretary of Defense (Health Affairs), “to promote the sharing of health-care resources” between VA and DOD. As is detailed elsewhere (see explanatory box on page 15), the Departments’ efforts to implement both the overall law and the specific requirement for a joint committee have been sporadic and uneven.

In the early years after enactment and continuing until the mid-1990s, what emphasis there was on VA/DOD sharing and collaboration was on local sharing arrangements, either at joint venture sites or through agreements to share specific resources at the local level. Little attention was paid to collaboration and sharing at the headquarters level of either Department, and the interagency leadership committee was dormant.

The Sharing Act was intended to make it easier for the two Departments to increase the variety and amount of health resource sharing for the benefit of their veteran and military beneficiaries, while helping hold down costs in federal health care.

In May 1996, the Secretaries of Veterans Affairs and Defense sent a joint report to the Vice President¹ emphasizing the need to plan sharing at the levels of the Veterans Integrated Service Networks (VISNs) and the DOD Health Services Regions. At the time this report was being prepared, efforts were underway to revive the interagency leadership committee.

Over the next several years, this committee, then known as the VA/DOD Executive Council, was periodically active and involved. However, there was not always a good record of its recommendations being implemented. For example, as is discussed in more detail in Chapter 3, VA and DOD in September 1998, based on a recommendation of the Council, agreed to implement a process for joint disability discharge physical examinations instead of duplicate examinations. Subsequent review by the General Accounting Office² indicated that only 21 VA facilities and 18 DOD facilities reported participating in the program, despite the fact that it had been approved by the Executive Council, a VA/DOD Memorandum of Agreement had been signed, and the Assistant Secretary of Defense (Health Affairs) had issued policy direction.

Since mid-2001, following the issuance of the Executive Order creating the PTF and the inclusion of VA/DOD cooperation in the President's management goals, there has been a renewed sense of purpose and momentum for VA/DOD collaboration.

In January 2002, the two Departments administratively established a new interagency leadership committee, the VA/DOD Joint Executive Council, co-chaired by the Deputy Secretary of Veterans Affairs and the Under Secretary of Defense (Personnel and Readiness). The PTF is encouraged by this current commitment to collaboration and sharing from the leadership of the two Departments and believes that the interagency leadership committee, as presently constituted, holds great promise for a continuation of that commitment.

PTF Findings

Since the signing of the Sharing Act, multiple initiatives attempted to enhance more effective and efficient coordination of medical resources between VA and DOD. However, results have been minimal or transitory. Prior Secretaries of Veterans Affairs and Defense have not been successful in establishing and institutionalizing common purposes and goals, creating measurements with common indices to monitor progress, demanding accountability, and promoting effective collaboration through incentives and other mechanisms. Committed leadership is essential to achieve VA/DOD collaboration.

¹ VA and DOD, "Report to the Vice President, Strategies for Jointly Improving VA and DOD Health Systems," May 1996.

² General Accounting Office, "VA and Defense Health Care: Evolving Health Care Systems Require Rethinking of Resource Sharing," (GAO-HEHS-00-52), May 17, 2000.

As described in Chapter 1, there have been numerous studies of VA and DOD collaboration and sharing over the years. Most of these studies have recommended joint strategic planning at the national and regional levels and identified lack of guidance and direction as a barrier to collaboration and sharing. These reports also documented the lack of monitoring and follow-up on joint decisions and policies, expressed concern over the lack of accountability, and concluded that the priority established by VA and DOD leadership for sharing was not clear at the regional and local levels.

Recommendations from these various studies have not been aggressively implemented. A primary reason for this lack of follow-through is the absence of a defined, consistent leadership structure at the national, regional, and local levels of either VA or DOD with clearly defined roles and responsibilities for implementing and institutionalizing recommended actions. Indeed, previous studies and reports have highlighted the lack of clear and concise corporate guidance for implementing collaboration initiatives. By most accounts, organizational and cultural barriers have consistently thwarted implementation. The operational levels within VA and DOD have not been routinely accountable to a clear set of directives, goals, measures, or strategic plans with regard to collaboration. Furthermore, there have been no processes implemented to foster communication and collaboration at the local and regional levels.

The PTF recognizes that inconsistencies exist not only at the VA and DOD departmental levels, but also among the Military Services within DOD, and that conflicting guidance from congressional oversight

Chronology of VA/DOD Oversight and Coordination Activity

- Public Law 97-174, the Veterans Administration and Department of Defense Health Resources Sharing and Emergency Operations Act, mandated the establishment of a VA/DOD Health-Care Resources Sharing Committee, to be chaired, in alternate years, by VA's Under Secretary for Health and the Assistant Secretary of Defense (Health Affairs).
- From 1982-1996, there was little attention paid to sharing and collaboration at the headquarters level of either Department.
- In May 1996, the joint committee, mandated in section 8111 of title 38, U.S. Code, was revived. The committee, then named the VA/DOD Executive Council, was chaired by the VA Under Secretary for Health and the Assistant Secretary of Defense (Health Affairs).
- In January 2002, the two Departments administratively established the VA/DOD Joint Executive Council, co-chaired by the Deputy Secretary of Veterans Affairs and the Under Secretary of Defense (Personnel and Readiness). The Joint Executive Council was established to provide oversight of the existing VA/DOD Executive Council (renamed the Health Executive Council) and a separate joint entity, named the Joint Benefits Council.
- The fiscal year 2003 National Defense Authorization Act (FY2003 NDAA) amended section 8111 of title 38, U.S. Code, so as to change the leadership of the joint committee specified in law from the level of VA's Under Secretary for Health and the Assistant Secretary of Defense (Health Affairs) to the level of the Deputy Secretary of Veterans Affairs and the Under Secretary of Defense. The effective date of this change is October 1, 2003.
- The Administration's fiscal year 2004 National Defense Authorization legislative request would amend the FY2003 NDAA provision so as to allow the new joint committee specified in law to address other issues in addition to health care resources.

committees has at times exacerbated the problem. The resulting confusion and policy barriers to optimizing collaboration between VA and DOD need to be resolved at the highest levels in the Departments. This resolution should include setting common purposes and goals, developing a joint VA/DOD strategic planning process designed to develop a shared vision, and forming a common set of objectives.

Success lies not in maximizing the number or dollar value of sharing agreements, but in implementing arrangements that result in the most cost-effective and timely delivery of quality care.

Coordination of the resource planning and budgeting process is particularly relevant to support joint purchasing, interoperative information management/information technology (IM/IT) systems, and prospective sharing of new facilities (see Chapters 3 and 4 for further discussion). A coordinated strategic budget process for collaboration is essential to ensuring that collaboration is integrated into both Departments' operating budgets and allocation methodologies. Interdepartmental partnering arrangements could be highlighted in VA and DOD budget submissions and should be a continual focus of the interagency leadership committee. Budget allocation to medical facilities, the final link, creates an environment for achieving the objectives of increased coordination and sharing.

Ultimately, implementation of goals and policies requires active monitoring and accountability. In fact, the Government Performance and Results Act of 1993 (Public Law 103-62) requires all federal departments to identify objective performance measures and incorporate them into their annual budget submission. Although both Departments have a broad variety of performance metrics, none of them measure the depth and breadth of VA/DOD collaboration and sharing, nor the impact of successful collaboration on various health care indices, such as improved access or reduced overall cost of furnishing services.

Defining and measuring success for interdepartmental cooperation is a difficult task. Success lies not in maximizing the number or dollar value of sharing agreements, but in implementing arrangements that result in the most cost-effective and timely delivery of quality care. The challenge is to adopt measures that establish incentives for efficient and effective use of resources within VA and DOD to promote optimal expenditure of public resources in the delivery of quality health care through enhanced collaboration. Neither VA nor DOD consistently provides incentives for leadership to foster VA/DOD collaborative efforts.

For VA, the most powerful tool to drive change has been the performance contract with the Directors of VA's 21 VISNs. Until recently, these contracts were not used to encourage VA/DOD sharing and collaboration. As part of the performance review and bonus justification beginning in fiscal year 2002, VHA senior executives were required to demonstrate initiatives in areas related to the President's Management Agenda, one of which is VA/DOD collaboration and sharing. For fiscal year 2003, two new criteria were included as performance measures for VISN Directors: 1) each is to submit one new initiative being conducted in collaboration with DOD; and 2) system-wide, VISN Directors should increase the dollar amount of VA/DOD collaboration initiatives.

In DOD, military and civilian personnel performance evaluations need not consider collaborative activities as a criterion, nor is there such a requirement in the performance contract for the Assistant Secretary of Defense (Health Affairs) with the Defense Resources Board. Two performance measures relative to sharing and joint procurement in the Military Health System Strategic Plan are, however, in the process of being refined.

When promotions and performance ratings are tied to performance on sharing and collaboration, overall outcomes should improve. Mechanisms should be developed to make all directors, commanders, practitioners, and managers in both Departments directly accountable to their superiors for the success of their collaboration and sharing activities once specific outcome expectations have been defined by the interagency leadership committee.

Conclusions and Recommendations

The Task Force is pleased with the renewed VA/DOD efforts in collaboration and sharing and with the organizational structures created to facilitate such efforts. For example, a March 2003 announcement by VA, DOD, and the Department of Health and Human Services of the first set of uniform standards for the electronic exchange of clinical health information is an important milestone in collaboration and serves as a model for all federal departments and agencies.

The previously established VA/DOD Health Executive Council has been active, and with the establishment of the VA/DOD Joint Executive Council, senior leadership of the Departments is clearly engaged. It is the responsibility of the leadership of the two Departments, starting with the Secretaries, to demand and ensure the success of VA/DOD collaboration.

The President established this Task Force to reinforce the importance of ongoing collaboration, in recognition of the sporadic level of effort demonstrated in the past. Once the Task Force ceases to exist, it will be critical for the President to continue to

stress to the Secretaries of Veterans Affairs and Defense the importance of collaboration and sharing. It is also essential to note that the overall goal of collaboration is to improve the timely delivery of high quality health care to the beneficiaries of the two Departments by working together in a cost-effective manner.

As described in the explanatory box on page 15, with the enactment of the fiscal year 2003 National Defense Authorization Act, it is not clear if the interagency leadership committee specified in law (named the VA-DOD Health Executive Committee) will have the same mandate as the existing VA/DOD Joint Executive Council, nor is it clear that a subordinate, health-specific entity chaired by the Assistant Secretary of Defense (Health Affairs) and VA's Under Secretary for Health will continue to exist.

Recommendation 2.1

Congress should amend the fiscal year 2003 National Defense Authorization Act to create a broader charter beyond health care for the interagency leadership committee. Additionally, consideration should be given to using civilian experts as consultants to the committee to bring in new perspectives regarding collaboration and sharing.

VA and DOD leadership need to clearly and jointly articulate what is expected as the end state of sharing and collaboration. The goal is not collaboration for mere collaboration's sake, but rather, through such activity, to improve timely access to quality health care and reduce the overall cost of furnishing services. There should be no ambiguity in the description of clear and measurable goals for improved cooperation. Once those in top leadership positions have communicated their directives, the Departments should follow by issuing plans in a timely manner, including performance expectations, measurements, and time lines with clear accountability. These plans should be communicated in a consistent manner to all levels of the two Departments and should be regularly reviewed for outcomes.

Recommendation 2.2

The Departments should consistently utilize a joint strategic planning and budgeting process for collaboration and sharing to institutionalize the development of joint objectives, strategies, and best practices, along with accountability for outcomes.

Recommendation 2.3

The Departments should jointly develop metrics (with indicated accountability) that measure health care outcomes related to access, quality, and cost as well as progress toward objectives for collaboration, sharing and desired outcomes. In the annual report prescribed in Recommendation 1.1, the interagency leadership committee should include these results and discuss the coming year's goals.

Leaders at all levels in the Departments should be held responsible and accountable for meeting desired outcomes of collaboration initiatives. Successful efforts should be publicly recognized and top performers rewarded. Those who fail to meet their goals should be required to submit written plans for improvement.

The successful implementation of many of the recommendations made in subsequent chapters of this report rests on the ability of the two Departments to work together toward a common goal. The interagency leadership committee will play a central role in implementing many of the more specific recommendations made in this report.

CHAPTER THREE

Providing a Seamless Transition to Veteran Status

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Between 1998 and 2002, over 784,600 individuals who are eligible for VA benefits left active duty service. In this same time frame, over 59,000 Reserve and National Guard members also separated who are eligible for VA benefits. Providing these individuals timely access to the full range of benefits earned by their service to their country is an obligation that deserves the attention of both VA and DOD. To this end, increased collaboration between the Departments for the transfer of personnel and health information is needed. Within VA, broader sharing of the information received from DOD and individual veterans is required so that veterans are not met at every turn with the question, “Who are you and what do you want?” A “seamless transition” from military service to veteran status is especially critical in the context of health care, where readily available, accurate, and current medical information must be accessible to health care providers.

VA and DOD have different missions that at times create inconsistencies and roadblocks to a uniform approach to health care delivery. Both systems are large, offering care at a total of more than 1,600 sites nationwide. There are over 300,000 personnel in both systems treating nearly 12 million beneficiaries. Each system faces the challenges of health care systems everywhere—new practices, techniques, and tools, changing demographics, aging infrastructure, and increasing costs. At the same time, access to health care is a growing concern for many Americans and the availability of health services provided through VA and DOD to beneficiaries is an increasingly important resource. For some veterans, VA may be their only health care provider.

A “seamless transition” from military service to veteran status is especially critical in the context of health care, where readily available, accurate, and current medical information must be accessible to health care providers.

Although veterans must be responsible for managing certain aspects of their health care, the two Departments should do everything possible to ensure a smooth transition from DOD to VA through collaboration at all levels. If a truly collaborative, veteran-centered health care model were adopted, the results would include not only improved patient satisfaction and health outcomes across the entire continuum of care, but also streamlined and efficient health care delivery, systems, and infrastructure.

To provide for a seamless transition, the two Departments should use standardized information nationwide. An institutional environment should be created in which information flows easily across all components of care, across geographic sites, and across discrete patient-care incidents while protecting privacy and confidentiality. In the words of the Transition Commission, “the lines limiting organizational jurisdiction and authority should be invisible to the service member or veteran crossing them.”

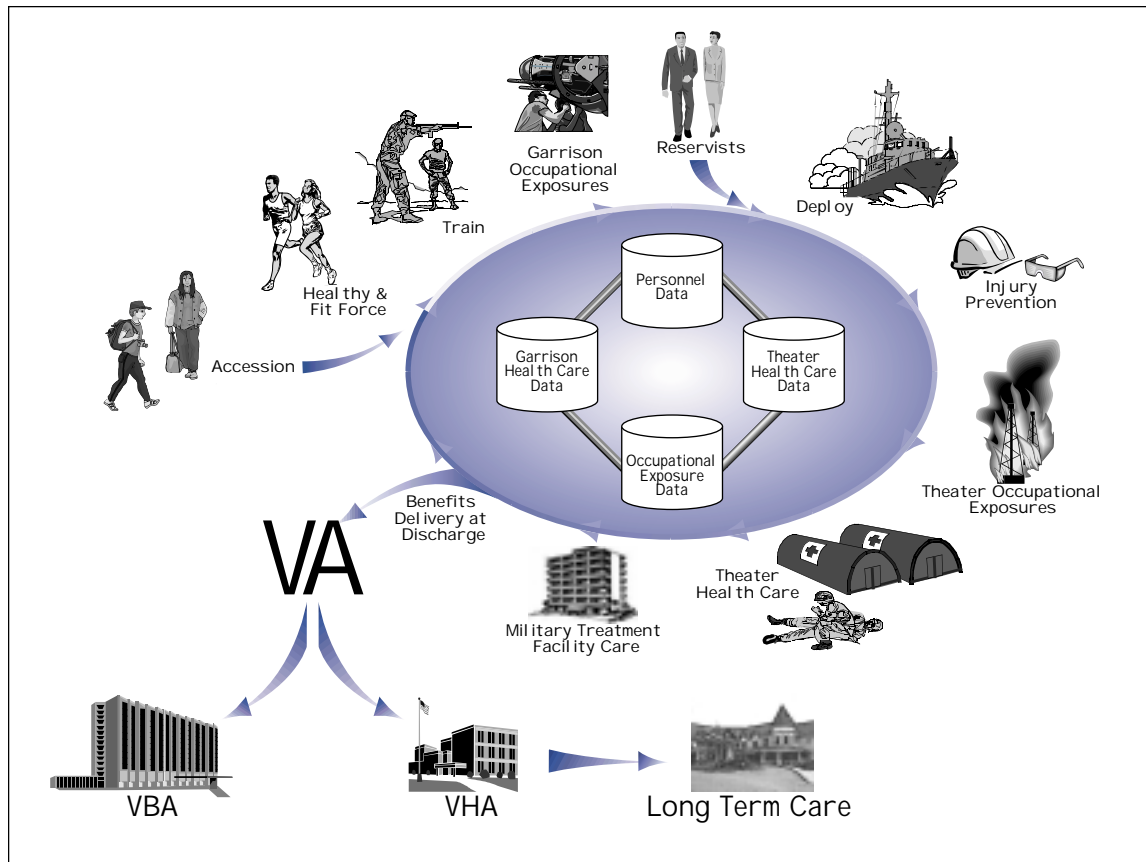
Barriers to a Seamless Transition

While in the military, service members and their families are enrolled in the DOD TRICARE program, in which individuals can receive care at DOD facilities or approved private providers, which include VA facilities. But once an individual makes the transition from military service to veteran status, he or she must apply separately for each VA benefit, such as disability compensation, health care, and education. If eligible for VA health benefits, a veteran has to learn the rules and limits of an entirely different health care system.

Separating service members with service-connected injuries or illnesses are most likely to seek care from and move directly into the VA health care system, using the full range of available transition assistance. However, most individuals completing their service do not have immediate health care needs and may not participate in all available separation processes when leaving the military, such as completion of a separation physical examination. Those who later seek VA health care may find the process for gaining entry into the system difficult, frustrating to navigate, and time-consuming—even though it is the continuation of the service member lifecycle begun while in military service (see Figure 3.1).

The VA/DOD processes for sharing information about eligible service members do not facilitate quick and accurate enrollment into VA programs. Veterans choosing to use the VA health care system must initiate the relationship with VA through an application process and, in some cases, a medical examination to establish priority classification. Therefore, from the perspective of veterans—including military retirees—the transition from military service to veteran status is far from seamless.

Figure 3.1 Service Member/Veteran Lifecycle



Both VA and DOD face significant issues in dealing with veterans who demonstrate unexpected health conditions as a result of possible exposure to occupational hazards during military service. For instance, DOD does not routinely collect and share with VA comprehensive occupational exposure data on individual service members. This essential information would assist VA in forecasting and preparing for changes in demand. Moreover, occupational exposure data are not collected in a formal or structured way across the Services. Without this information, it is difficult for VA to correlate exposures to occupational hazards incurred while in military service to subsequent medical problems.

Similarly problematic is the fact that VA does not provide information back to DOD with respect to health care problems of former service members. Feedback from VA to DOD could enable DOD to develop better preventive methods to minimize risks to troops exposed to occupational hazards.

A process of seamless transition should include timely and straightforward access to information needed to determine eligibility for benefits and meet the health care requirements of veterans. Such a process should also include the ability of DOD to provide VA service personnel data and for the two Departments to readily share electronic medical record (EMR) data. Furthermore, when a veteran seeks access to VA health care because of a confirmed or suspected service-related illness or injury related to possible exposure to occupational hazards during military service, it is critical that VA and DOD share information about diseases or illnesses that could be associated with such exposures, or that could assist in epidemiological research efforts.

The Need for a Standards-Based Electronic Medical Record

The VA and DOD electronic medical record systems were developed separately and cannot readily share data. Since there is a limited process for electronic transfer of patient records at the time of separation, treatment for those seeking VA care is not easily coordinated between DOD and VA. Also, in the event of war or national emergency, VA is the back-up health care delivery system for DOD. If a large number of casualties were incurred, the ability to know the health status of military personnel would become a matter of national security; however, there are no interoperable data systems or processes to enable sharing of this information electronically between the two Departments.

The development and use of interoperable, bi-directional EMRs would facilitate collaboration in the delivery of health care services, enhance effectiveness of care, and reduce medical errors and attendant costs.

The development and use of interoperable, bi-directional EMRs would facilitate collaboration in the delivery of health care services, enhance effectiveness of care, and reduce medical errors and attendant costs. With such systems in place, VA and DOD health care providers would have access to complete information about a veteran's health status whenever and wherever required. Both Departments' EMR systems would be able to readily and easily exchange appropriate health information in mutually understood and usable formats. Health care managers and analysts would have access to the detailed clinical and resource information necessary to plan and manage health care services for VA and DOD beneficiaries.

Interoperable EMRs also would improve timeliness of benefits determination, continuity and quality of care, as well as provide added convenience for VA and DOD beneficiaries. For providers, interoperable EMRs would reduce delays in access to patient information,

increase efficiency, and reduce paperwork and costs. In addition, an EMR system is the most effective tool to implement clinical practice guidelines (CPGs), evidence-based statements that help patients and health care providers make appropriate decisions about care. Their use has evolved in response to studies demonstrating significant variations in risk-adjusted practice patterns and costs. Experts see clinical practice guidelines as a potential solution to inefficient and inappropriate variation in care.

Standards-based, interoperable EMRs also would facilitate data use for longitudinal epidemiological studies, the results of which could benefit all veterans. The interoperability of health information systems would also allow VA-generated data to be incorporated into the DOD medical records of dual-eligible individuals and vice versa.

While both Departments are independently developing information system capabilities to capture full medical histories, they have only just begun to implement the necessary policies, practices, and data standards to govern appropriate sharing of information.

The Departments have only just begun to implement the necessary policies, practices, and data standards to govern appropriate sharing of information.

Recommendation 3.1

VA and DOD should develop and deploy by fiscal year 2005 electronic medical records that are interoperable, bi-directional, and standards-based.

The EMR systems should: 1) incorporate VA and DOD CPGs into patient care; 2) incorporate comprehensive inspection of drug-drug and drug-allergy interactions across all DOD and VA sources of health care; 3) cover the full lifecycle of a service member/veteran to support continuity and high-quality care, as well as epidemiological studies; 4) be compliant with security and privacy regulations; and 5) be based on existing health data standards, or where these are lacking, based on a mutually-adopted VA/DOD enterprise reference terminology for the areas of highest priority (see Appendix D for more in-depth discussion).

Privacy and VA/DOD Sharing of Medical Information

The provisions of the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191) (HIPAA) must be considered while pursuing the goal of VA/DOD sharing of health information. In general, HIPAA Privacy Rules (National Standards to Protect the Privacy of Personal Health Information) prohibit the nonconsensual disclosure to certain

third parties of personally identifiable health information. An exception¹ specifically provides VA and DOD the basis for the one-way sharing of health data, at the time of separation only, provided by DOD to VA through the Federal Health Information Exchange (FHIE) program. However, HIPAA Privacy Rules do not enable DOD to share post-retirement data or VA to share data with DOD (see Figure 3.2). This exception also allows data from DOD to be used throughout VA to determine eligibility for VA benefits.

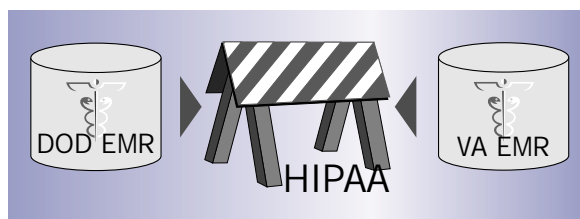
The Department of Health and Human Services (HHS) "Section-by-Section Description of Final Modifications and Response to Comment" on HIPAA Privacy Rules, published in the *Federal Register* on August 14, 2002, permits the Departments to share information on individuals being treated in both systems. Section 164.506(a) "provides regulatory permission for covered entities to use or disclose protected health information for treatment, payment, and health care operations." However, "such disclosures would be permitted only to the extent that each entity has, or had, a relationship with the individual who is the subject of the information being disclosed. Where the relationship between the individual and the covered entity has ended, a disclosure of protected health information about the individual would be allowed only if related to the past relationship." This provision does not allow DOD to routinely send post-retirement information on all individuals who continue to receive care from DOD, but only for those whom DOD is certain are also being treated within the VA health care system. This is consistent with the general requirements of HIPAA, which permit the sharing of health information between providers who are treating the same individual.

Currently, DOD uses the FHIE to send to VA laboratory and radiology results; outpatient pharmacy information from military facilities; discharge summaries; admission, discharge, and transfer information; and demographic information at the time of separation. In the current fiscal year (2003), the FHIE will also convey allergy information and consult reports, subject to the same limitations applied to previous data transfers. This system does not

provide an enterprise-wide mechanism for VA data to be shared with DOD.

The Departments are working together to provide fully interoperable health data systems by fiscal year 2005. They are collaborating

Figure 3.2 HIPAA acts as a barrier to easy sharing of health data between DOD and VA



¹ The exception is at 45 CFR 164.512(k)(1)(ii).

to ensure compatibility of DOD's clinical data repository and VA's health data repository to fully support health care-related information exchange requirements and to ensure availability of the appropriate information for epidemiological studies.

In fiscal year 2002, VA requested and was denied by HHS a special exemption from the Privacy Rule for VA/DOD collaboration for ongoing health care. Thus, if departmental sharing is to occur for the benefit of veterans individually and collectively, further action must be taken.

Recommendation 3.2

The Administration should direct HHS to declare the two Departments to be a single health care system for purposes of implementing HIPAA regulations.

If the Departments are not declared to be a single health care system for the purpose of implementing HIPAA regulations, a much more cumbersome process will be needed to enable them to share health information within the confines of HIPAA Privacy Rules. DOD would need to continue the current system of triggered disclosure at the time of separation. In addition, the Departments would need to establish a mechanism whereby each Department would electronically share information about current patients who could potentially be treated in the other system. It would be difficult to keep such a system up-to-date. The new VA-DOD interagency leadership committee would need to take a proactive role in establishing policies and practices addressing HIPAA compliance in order to facilitate interdepartmental collaboration.

Single Separation Physicals and “One-Stop Shopping” to Determine Veteran Benefit Status

Upon discharge or retirement, service members should have an easy and timely transition to veteran status. When an individual is separated from military service, he or she is issued a DD214, which includes dates of service, type of discharge, foreign service, medals received, and other personnel data, and his or her personnel file and health records are forwarded for storage. To access health care services in the VA system, a veteran needs the DD214 as well as a determination of health status. VA has identified untimely access to the service member's DD214 as a major factor delaying determination of benefits.

In 1998, to facilitate transition to veteran status, VA and DOD developed a national policy under which separating or retiring service members expecting to file a claim for VA disability

compensation would undergo a single physical examination prior to discharge. The purpose of this initiative was to eliminate lengthy delays in claims decisions and health care eligibility determinations. VA guidance implementing this initiative, the Pre-discharge Physical Examination Program, established a target of adjudicating approximately 64,000 claims per year under the program.²

In 1999, a review found that DOD's implementation of this single exam varied in levels of interest, support, and oversight, with local interests prevailing instead of the concept of long-term cost avoidance for the government as a whole.³

In fiscal year 2001, over 250,000 service members separated from military service. VA estimated that 80,000 of these individuals would file claims with VA; however, only 23,500 claims (less than one-third of the target) were adjudicated with a single physical exam. As a result, many individuals had to have two physical exams with delayed disability ratings. The separation physical as currently performed by DOD is very different from that performed by VA, the purpose of which is to help determine the need for a compensation and pension (C&P) examination.

To accelerate determinations of benefits and increase access to care for those veterans determined to be eligible, all service members should receive a mandatory physical prior to separation as a prerequisite of completing the separation process and issuance of the electronic DD214. There is no uniform requirement for a separation or retirement physical among the Military Services. The Departments should determine how best to meet this goal and where time and cost-saving measures could be implemented. For example, in those cases in which a separating service member chooses to initiate a claim for veterans' benefits, the C&P exam could serve as the separation physical exam.

Recommendation 3.3

The Departments should implement by fiscal year 2005 a mandatory single separation physical as a prerequisite of promptly completing the military separation process. Upon separation, DOD should transmit an electronic DD214 to VA.

The purpose of this recommendation is to establish a health baseline for all service members separating from the military service, facilitate the claims process for those choosing to submit a claim, eliminate duplicate physical exams at the time of separation,

² Veterans Benefits Administration Circular 20-98-2, "Veterans Benefits Administration Pre-Discharge Claims Development, Examinations, and Rating Decisions," May 19, 1998.

³ Birch and Davis Associates, A Review of the Pre-discharge Physical Examination Program, November 1999.

and provide VA with an electronic DD214. Any findings in the separation physical that warrant further investigation with respect to compensation would be promptly assessed through appropriate components of the C&P exam.

The concept of “one-stop shopping,” in which a separating service member receives a separation physical, claimant counseling, and outreach to explain the full range of VA benefits in a consolidated setting, currently exists in several delivery models. Examples include the availability at DOD facilities of fully functioning VA satellite offices, functional Veterans Benefit Administration (VBA) presence, and itinerant VA services. Those few military bases that have a fully functioning VA satellite office provide one physical examination that meets the needs of both Departments, as well as full outreach services, claimant counseling, rating, and claims adjudication. These one-stop shopping models optimize customer service and efficiencies, and can reduce expenditures.

The concept of “one-stop shopping” currently exists in several delivery models.

Recommendation 3.4

VA and DOD should expand the one-stop shopping process to facilitate a more effective seamless transition to veteran status. This process should provide, at a minimum:
1) a standard discharge examination suitable to document conditions that might indicate a compensable condition;
2) full outreach; 3) claimant counseling; and 4) when appropriate, referral for a Compensation and Pension examination and follow-up claims adjudication and rating.

For more remote installations, it may be necessary to send separating service members to an existing or subsequently established one-stop shopping site for this process.

DOD might need to secure additional resources, or redirect existing resources, to establish or expand and maintain one-stop shopping sites on military installations and to provide the electronic DD214. VA also may need additional funding in order to establish, expand, and maintain one-stop shopping sites, to accept and use the electronic DD214, and, until a complete medical record is available electronically, to ensure that any medical records used by VBA are also made available to the Veterans Health Administration (VHA).

Collecting and Sharing Comprehensive Service Member Data to Determine Effects of Service on Veteran Health

Both VA and DOD face significant issues in dealing with veterans who develop health conditions as a possible result of exposure to occupational hazards during military service. For example, it has been very difficult to respond to concerns about relatively recent exposures, such as Agent Orange in the Vietnam conflict and occupational hazards in the Persian Gulf War in 1991. In these instances, it was difficult to correlate unexpected health conditions with exposures due to a lack of data on where individuals served, environmental conditions, and personal exposures. The threat of increasing availability of biological and chemical weapons makes it imperative that this type of information be gathered in future conflicts.

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Historically, DOD did not appear to view collection of medical surveillance information as a defined requirement. Although DOD has numerous instructions on various specific occupational exposures, there has been no overarching policy framework, and collection efforts within DOD have not been coordinated under one program. The Services have not consistently attempted to collect information on individual assignments during deployments, conduct pre- and post-deployment surveys, or track occupational exposure during military service. Furthermore, policies for maintenance of records of military operations vary significantly across the Services.

More recently, in February 2003, the Defense Department reported plans to ensure that "force health is closely monitored through a series of medical assessments before and after deployment and that health concerns are closely documented and closely monitored." In addition, DOD has established separate deployment health centers for health surveillance, health care, and health research. They will focus on the prevention, treatment, and understanding of deployment-related health concerns. Improvements in deployment-related medical record keeping are also on the horizon.⁴

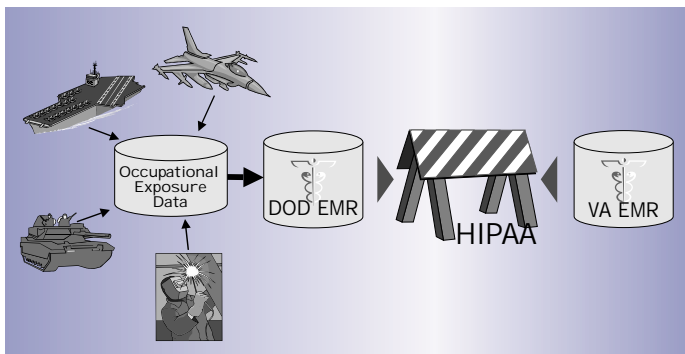
Despite this new emphasis, DOD has not established a requirement to share with VA comprehensive service member data on assignment history, individual location during deployments, occupational exposure, and injuries. This information could help VA better forecast and prepare for changes in demand, plan for delivery needs, and conduct epidemiological studies. It also could help VA establish service connection for benefits determination,

⁴ Armed Forces Press Service, "Pentagon Has New Strategy for Monitoring Deployment Health Care," February 11, 2003.

promote ongoing care for individuals, and correlate exposure to occupational hazards incurred while in military service to subsequent medical problems. Provider access to this information could enhance understanding of the experiences that might be affecting a veteran's health. For the veteran, better analysis of occupational exposures could provide answers that would reduce or eliminate the need for lengthy individual case examination, delayed proactive treatment and benefits, and additional distress and health care needs (see Figure 3.3).

Providing VA occupational exposure data, however, must be weighed against the potential security concerns of releasing these data, as in matters involving individual location for certain types of individuals, such as Special Forces, or assignment detail for sensitive areas.

Figure 3.3 Complete occupational exposure data is not captured and shared



The Departments will need to collaborate to determine which data will be released and the time frame for release. The Departments should establish coordinated policies governing the collection, use, and maintenance of these data that appropriately address national security concerns without inappropriately using security as a basis to limit legitimate sharing of data.

There is also a potentially large pool of occupational exposure data—analogous to the exposure data collected on radiation workers—that are related to routine work assignments, such as fuel handlers or painters, for which there is little national security risk. The routine exposures of our fighting forces at work in garrison, in port, or in routine operations should be monitored, recorded, and managed in a coherent, comprehensive policy framework that includes, as an integral feature, VA/DOD collaboration and information sharing.

A retrospective analysis of military service experiences and subsequent health problems provided by VA to DOD, combined with DOD's own epidemiological studies and analysis, could enhance DOD's ability to improve military health readiness and prevent or ameliorate future adverse health events resulting from exposures. The epidemiological studies and analysis conducted by VA, or VA and DOD jointly, should be used to provide appropriate feedback to DOD to consider issues related to weapons design, training, and operational practices and policies to augment DOD's own studies and analyses.

In 1998, a Presidential Directive established the Military and Veterans Health Coordinating Board. The Secretaries of Defense, Veterans Affairs, and Health and Human Services served as co-chairs of the Board. The Board's charter stated:

The primary mission of the Board is to ensure coordination among the Departments of Veterans Affairs, Defense, and Health and Human Services on a broad range of military and veterans' health matters to achieve the Nation's commitment to maintain, protect and preserve the health of the men and women who serve in the U.S. Armed Forces. The Board addresses health matters that relate to military service with a primary focus on the health of military members, veterans, deployed civilians, and their families during and after future combat and other operations.

However, the co-chairs dissolved the Board in 2002. Following its suspension, the interagency leadership committee established a Work Group on Deployment Health. This work group has met only sporadically and lacks sufficient staff to address interagency coordination on deployment health issues. Because of the importance of leadership attention and commitment to this issue, the interagency leadership committee should formally facilitate the Departments' coordination and collaboration to address the impact of occupational exposures, including deployment health issues.

Recently developed management tools could help in future determinations of deployment histories and possible occupational exposures:

- In response to concerns about the health effects of service in the Gulf War, Congress mandated a DOD medical surveillance program. The Personnel Tempo (PERSTEMPO) tracking system was designed to strengthen management of individual service members' periods away from their home station. It also has the potential to provide more detailed data on individual service member locations.
- When fully implemented in 2006, the Defense Integrated Military Human Resources System (DIMHRS), a consolidated personnel and pay system, will be a significant step forward in providing a single record of service and service-related activities. This will assist separating military personnel by providing the documentation necessary to

receive timely access to benefits. However, many elements related to tracking an individual's specific location, activities, and exposures will remain undocumented.

- The Defense Occupational and Environmental Health Readiness System (DOEHRS) is designed to support the Hearing Conservation, Industrial Hygiene, and Occupational Medicine programs within the Military Health System.

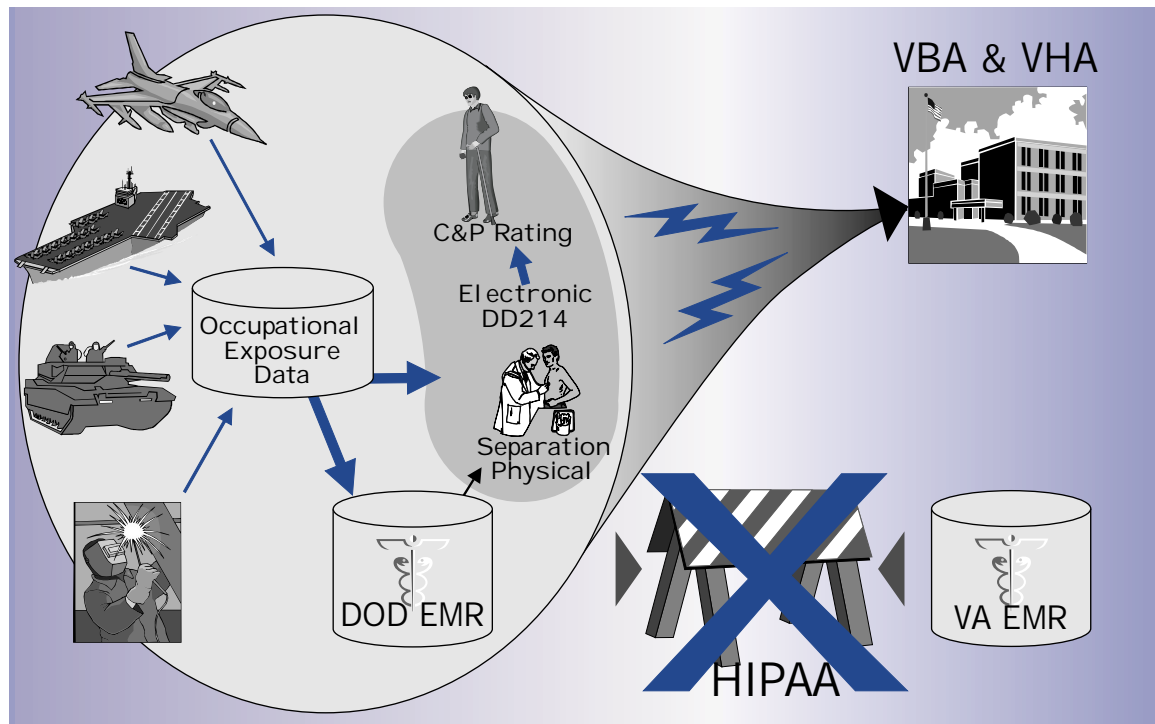
These initiatives should enhance DOD's ability to collect relevant information on service members and their potential exposure to occupational hazards during service, but DOD must adopt specific policies on sharing such information with VA to support the continuity of health care of veterans.

The Departments are collaborating on the Millennium Cohort Study, which will assess the health of 100,000 to 140,000 service members throughout their military careers and after they leave service. This project is designed to evaluate the impact of military deployments on various measures of health over time, including medically unexplained symptoms and chronic diseases. The study includes Active, Reserve, and National Guard personnel who have deployed, as well as those who have not deployed.

To provide a "life-long" medical record, data must be captured routinely, beginning with an individual's accession into military service and continuing throughout his or her career (see Figure 3.4). If DOD's Composite Health Care System (CHCS II) were available at the time of entrance into the military, baseline health data could be routinely captured. Pilot testing began in 2002 of the Recruit Assessment Program (RAP). This DOD program facilitates the routine collection of baseline demographic, medical, psychosocial, occupational, and health risk factor data from all U.S. military personnel at entry into the armed forces. Either through the RAP program, if its feasibility is demonstrated, or through some other initiative, establishing an accession baseline is important to providing a complete military medical record.

To provide a "life-long" medical record, data must be captured routinely, beginning with an individual's accession into military service and continuing throughout his or her career.

Figure 3.4 Proposed information sharing at time of separation



Frequently, long-term follow up is necessary to identify delayed adverse consequences of occupational exposures. In September 2002, a VHA Directive⁵ established a new policy for offering health care to recent combat veterans for a two-year period beginning on the date of the veteran's discharge for any illness, even if there is insufficient medical evidence to attribute the illness to military service. VA currently lacks the authority to conduct continuous health surveillance beyond this two-year period, a deficiency that hinders the timely determination of benefits and treatment of possibly affected veterans.

The PTF applauds the progress on the systems and activities described above. They represent significant milestones in the development and deployment of a flexible, coherent suite of repositories to meet current and emerging needs for personnel, workplace, and other environmental surveillance data. The PTF makes the following recommendations to build on the progress to date.

⁵ VHA Directive 2002-049, "Combat Veterans Are Eligible for Medical Services for 2 Years After Separation From Military Service Notwithstanding Lack of Evidence for Service Connection," September 11, 2002.

Recommendation 3.5

VA and DOD should expand their collaboration in order to identify, collect, and maintain the specific data needed by both Departments to recognize, treat, and prevent illness and injury resulting from occupational exposures and hazards experienced while serving in the Armed Forces; and to conduct epidemiological studies to understand the consequences of such events.

Recommendation 3.6

By fiscal year 2004, VA and DOD should initiate a process for routine sharing of each service member's assignment history, location, occupational exposure, and injuries information.

Recommendation 3.7

The Departments should: 1) add an ex officio member from VA to the Armed Forces Epidemiological Board and to the DOD Safety and Occupational Health Committee; 2) implement continuous health surveillance and research programs to identify the long-term health consequences of military service in high-risk occupations, settings, or events; and 3) jointly issue an annual report on Force Health Protection, and make it available to the public.

The recommended annual report on Force Health Protection should include information on the extent to which the Departments are able to: 1) recognize illness and injury resulting from occupational exposures and hazards encountered during military service; 2) treat veterans for such illness and injury; and 3) conduct epidemiological studies to understand the consequences of occupational exposures and hazards and develop information on issues related to weapons design, training, and operational practices and policies.

The PTF believes that responsiveness is fundamental to achieving the objectives set forth in these recommendations. Experience has shown that the health concerns of veterans too often have remained unresolved because of lack of data. Missing records, absence of baseline health data, inaccurate records of troop locations, and incomplete data on the

health effects of exposure have created significant problems for veterans seeking treatment and benefits. In 1996, the Presidential Advisory Committee on Gulf War Veterans' Illnesses wrote in its final report, "The government has a significant amount of ground to recover with Gulf War veterans and the American public, who have come to question whether a lack of data . . . indicates a lack of commitment to veterans' health."⁶ To regain that trust, the Departments must be more proactive in collecting, analyzing, and using all available data relating to possible occupational exposures and hazards.

Summary

VA and DOD responsibility for veterans' health begins as soon as an individual enters the Armed Forces. Collecting and capturing baseline medical information upon entry into the military in an interoperable, bi-directional, and standards-based EMR is the first step in the process. During military service, information relevant to a service member's deployment, occupational exposures, and health conditions should follow the service member through his or her military career. Once an individual separates from military service, the process for determining benefits, assessing health status, and receiving care through the VA health care system should be seamless, timely, and accurate. Better recording, tracking, and reporting of occupational health data will improve the research base for understanding the etiology of service-related disorders, assist in benefits determination, and improve the overall health of today's veterans as well as those who will follow them in the future. These goals can only be accomplished through systems that are standards-based and coordinated between VA and DOD.

⁶ Presidential Advisory Committee on Gulf War Veterans' Illness: *Final Report*, Washington, D.C., U.S. Government Printing Office, December 1996.

CHAPTER FOUR

Removing Barriers to Collaboration

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Removing Barriers to Collaboration

The Sharing Act, as discussed in Chapter 2, was intended to encourage greater efficiencies and increase the variety and amount of health care resource sharing for the benefit of veteran and military beneficiaries. Since its enactment in 1982, the health care delivery systems of VA and DOD have significantly evolved, but not always toward the intended goal of sharing.

VA and DOD have a mixed record in carrying out the mandates, both statutory and administrative, to improve coordination and sharing. Joint contracting for pharmaceuticals has been one of the bright spots, with a total cost avoidance of \$369 million in fiscal year 2002. Other contracting areas and the direct sharing of goods and services, however, have seen more limited progress. According to GAO, in fiscal year 1998, direct sharing of services to beneficiaries constituted less than \$60 million of a combined health care budget that exceeded \$40 billion. Of this amount, 75 percent of all inpatient sharing was provided at just 12 facilities, and 75 percent of all outpatient sharing, at just 15 facilities. DOD purchased \$28 million in health care services from VA, while VA purchased \$20 million from DOD.¹ Of the 134 VA hospital TRICARE network providers, the total value of services provided by VA facilities as a network provider was only \$9.8 million in fiscal year 2001.²

VA and DOD have a mixed record in carrying out the mandates, both statutory and administrative, to improve coordination and sharing.

As mentioned in Chapter 2, collaboration and sharing in the past between the Departments have been impeded by the lack of joint strategic planning to support a common vision and set of objectives for interdepartmental partnering, but considerable progress is now underway. Eliminating policy and program barriers between VA and DOD and institutionalizing the processes that promote collaboration and communication are essential components of necessary procedural reform.

¹ General Accounting Office, "VA/DOD Health Care: Evolving Health Care Systems Require Rethinking of Resource Sharing Strategies" (GAO/HEHS-00-52), May 17, 2000.

² VA Office of Medical Sharing in response to PTF data call.

This chapter focuses on identifying existing barriers to collaboration and describing how such barriers should be addressed. In addition, this chapter discusses ways to create incentives for greater collaboration and develop standardized, cooperative practices to facilitate collaboration.

There are certain differences between the Departments that will continue even if there is an increase in the level of collaboration and sharing.

Successful partnering between VA and DOD occurs when it is to the advantage of both parties and only if sound business principles exist in a stable business environment. Such a state can only occur when there is viable strategic planning for partnership, accurate forecasting and budgeting, and a consistent resource allocation methodology—processes that have not existed in the past but that are presently under development.

Coordination of the resource planning and budgeting processes is particularly relevant to support collaborative purchasing, interoperable IM/IT systems, and prospective sharing of new facilities. Joint strategic planning would also support

the creation of human resource management systems to allow the interchange of human capital across systems. This would facilitate the delivery of health care to all beneficiaries in a seamless business environment that nonetheless supports and sustains the missions of both Departments.

There are certain differences between the Departments that will continue even if there is an increase in the level of collaboration and sharing. Some of the more significant ones include: mission differences and priorities; a resource-constrained environment (discussed in Chapter 5); different care delivery strategies and benefits; location of facilities relative to the beneficiary population; different management and financial systems; and different clinical systems.

As described in Chapter 2, the organizational structure to support, facilitate, and implement collaboration and sharing between the two Departments is now in place through the interagency leadership committee, which has undertaken a strategic planning initiative for interdepartmental sharing. This committee can take a lead role in developing new approaches to improving collaboration, including:

- structural and procedural improvements through better alignment of management entities and business practices within and between the Departments and increased efforts in joint contracting; and

- categorical improvements in resource management and sharing—specifically, IM/IT, facilities and joint venture sites, and personnel.

Improvements in these programmatic and administrative areas may not be readily apparent to the casual observer. However, enhanced procedural, administrative, and functional alignments will create efficiencies and economies of scale in both systems and are, therefore, likely to improve health care delivery and efficiency as well.

The Impact of VA and DOD Organizational Structures on Collaboration and Sharing

In October 1995, VHA reorganized with goals of reducing the span of control, developing a more responsive health care system, and providing health care delivery more closely matched to local health care needs. The reorganization created 22 (subsequently reduced to 21) Veterans Integrated Service Networks (VISNs), the basic budgetary and planning unit of the new system. Each VISN director manages between three and 11 medical centers. Thus, the span of control for VA headquarters was transformed from four regions to 21 VISNs.

Because the VHA reorganization created delivery systems that aim for responsiveness to local situations and needs, the system varies from one network to another. While this attention to responsiveness may have achieved some goals, it has fallen short of others. In the course of site visits (see Appendix E), the PTF found that VA's intentional de-emphasis on centralized decision making and subsequent lack of consistent business processes and structures have led to considerable variation in health care delivery and business program management across the VA health care system. For example, VISNs have adopted significantly different approaches to furnishing long-term care services. Some emphasize utilization of in-house facilities and State Veterans Homes while others place more emphasis on providing home-based services. Similarly, VISNs differ in how they furnish telephone care and after-hours services—in one network, these services are contracted to the private sector; in another area, three networks have banded together to provide services; and in yet others, daytime access to services is provided through clinics.

VA's intentional de-emphasis on centralized decision making and subsequent lack of consistent business processes and structures have led to considerable variation in health care delivery and business program management across the VA health care system.

The DOD health care system has undergone significant changes as well. In the 1990s, the DOD Military Health System (MHS) was moving toward a system of managed care, capitation-based resourcing, and shifting of care delivery from the inpatient to outpatient setting. DOD undertook extensive changes in the organization of its health care system with the transition from CHAMPUS to the TRICARE program. Initially, TRICARE restructured the MHS into 12 Health Services Regions, each administered by a Lead Agent who coordinates with the commanders of military treatment facilities (MTFs) in his or her region to develop an integrated health care delivery plan.

Currently, DOD contracts with four managed care companies to provide a network of services to augment the care provided in the direct care system of military hospitals. These multi-billion dollar contracts cover 12 multi-state regions and require a full range of clinical and administrative services. In late 2002, DOD initiated a system-wide procurement effort to replace existing contracts with a new model that consolidates the 12 regions into three and alters the types of services required, as well as reimbursement methods.³ Awards are to be made in mid-2003 with service delivery to begin in June 2004.

Since the inception of TRICARE, VA and DOD have wrestled with the appropriate role for VA in such contracts. Before TRICARE, sharing arrangements and referrals were made directly between VA and DOD facilities; however, with the advent of managed care support contracts, DOD facilities are required to send most TRICARE beneficiaries through the network. When VA facilities became TRICARE network providers in 1996, many found that meeting TRICARE standards for appointment availability, limits on beneficiaries' travel distance requirements, and network standards for submitting claims limited their opportunities to accept referrals as network providers. Many of these problems were exacerbated by the resource constraints that VA facilities have faced in recent years.

Although VA has had input into developing specifications for the new contracts—with most of the focus being on the ability of local hospitals to directly enter into sharing agreements—further savings could likely be achieved by increased VA participation in TRICARE and its contracting operations. However, significant barriers remain, including:

- the ability of VA to meet TRICARE access standards, especially in light of the current mismatch between demand and available funding in VA (see Chapter 5), resulting in a significant waiting list;
- the potential for displacement of VA beneficiaries by DOD beneficiaries;
- agreement on levels of reimbursement to both parties; and
- VA difficulties in producing accurate bills for reimbursement.

³ Request for Proposals dated August 1, 2002, MDA 906-02-R-0006.

DOD is moving aggressively to replace current contracts viewed as costly and difficult to manage. It will be important for the interagency leadership committee to monitor the implementation of these next-generation TRICARE contracts and identify obstacles and opportunities for further VA/DOD collaboration. Meanwhile, problems remain in the DOD system in terms of its ability to collaborate with VA. The Lead Agents in the MHS have no command and control authority over MTFs within their region; the three military Departments implement policy at the Service level for their respective facilities. This lack of clear command, control, and communications may inhibit the overall performance of the DOD system and constrain its ability to conduct meaningful regional collaboration with VA.

Besides the impact of the emerging organizational structures, a number of observers have noted barriers to collaboration created by the differing geographical boundaries of the DOD regions and VISNs. For example, an MTF commander whose territory encompasses more than one VISN frequently encounters different policies, standards, and practices between and among networks. Because of the differences in geographical boundaries and lack of standardized policies and practices, the PTF believes changes are needed to facilitate collaboration.

VA and DOD should structure themselves in a manner that best accomplishes their respective missions. However, if organizational structures impinge on the ability of both health care systems to effectively collaborate, the Departments should work together to address these barriers.

The reorganization of VHA in 1995 was intended to address concerns that its health care system had become overly bureaucratic and cumbersome. Although the VISN structure successfully decentralized the system, it also has resulted in the growth of disparate business procedures and practices. The VISN structure alters the ability to provide consistent, uniform national program guidance in the clinical arena, the loss of which affects opportunities for improved quality, access, and cost effectiveness. It is the PTF's opinion that the structure and processes of VHA should be reviewed.⁴

*A number of observers
have noted barriers to
collaboration created by
the differing geographical
boundaries of the DOD
regions and VISNs.*

⁴ In May 2002, VHA was restructured in an effort to better implement policy directives across its 21 VISNs and ensure that VHA operates as an integrated national health care system rather than as regional health care systems. It is not yet clear whether this latest restructuring will accomplish its objectives.

Recommendation 4.1

The Secretaries of Veterans Affairs and Defense should revise their health care organizational structures in order to provide more effective and coordinated management of their individual health care systems, enhance overall health care outcomes, and improve the structural congruence between the two Departments.

Collaboration through Standardized Business Processes, Practices, and Incentives

Despite the independent success of the Departments in improving management of their health care systems, over the past few years it has become increasingly apparent that coordination between the two Departments has not resulted in significant improvements in resource sharing and standardized business processes. In a 2000 report, GAO noted several disincentives to interdepartmental sharing in the area of financial management, including inadequate and incompatible budget, reimbursement, and cost accounting systems.⁵

In assessing these issues, the PTF reviewed previous reports on VA/DOD collaboration, conducted a survey of numerous joint venture and other co-located sites, and conducted numerous site visits (see Appendix E). During the site visits, a number of barriers to collaboration at the facilities level emerged, including:

- lack of a stable business environment with standardized and effective business rules, processes, practices, and unambiguous guidance on collaboration;
- no standardized, effective, and responsive process for submitting business proposals up through the chain of command and no expectation that the requester will receive the legally required response within 45 days;
- no means to provide local incentives for collaboration; and
- lack of a process to mitigate the risks associated with entering into collaborative agreements with a party that might be unable to carry out its part of the agreement because of unanticipated deployments or other unexpected loss of key staff.

At the site visits, VA and DOD staff were asked what could be done to increase their willingness to collaborate and share. Common answers from staff of both Departments included: 1) providing seed money to fund good ideas, programs, or projects;

⁵ GAO, "VA/DOD Health Care: Evolving Health Care Systems" (GAO-HEHS-00-52), May 17, 2000.

2) providing rewards for successful collaboration; and 3) mitigating risk in cases where one partner could not fulfill its part of a collaboration agreement.

Based on this input, the PTF believes that a key action to support increased collaboration would be to provide supplemental funds, jointly administered to:

- reward excellence by providing additional resources to expand on innovative and creative sharing and collaboration initiatives;
- fund start-up and other costs associated with collaboration and sharing; and
- mitigate risks of entering into collaborative agreements where one party cannot fulfill the agreement because of unanticipated deployment or other unexpected loss of key staff.

At the local level, a number of VA and DOD health care organizations are developing meaningful, collaborative relationships that are improving health care delivery to veterans. This is generally occurring when there is a mutually identified need to improve services and there is very focused and committed local leadership. However, what is missing in the effort to replicate such successes system-wide is a standardized and effective business framework that provides consistent and unambiguous guidance to local health care leaders. There is also a need for a systematic process to identify and adopt best practices across the two Departments. Areas where there are opportunities to improve standardization and effectiveness include business case analyses, financial processes, clinical workload counting, productivity measurement and improvement, and human resources systems.

Recommendation 4.2

The Secretaries of Veterans Affairs and Defense, based on the recommendations of the interagency leadership committee, should provide significantly enhanced authority, accountability, and incentives to health care managers at the local and regional levels in order to enhance standardized and collaborative activities that improve health care delivery and control costs.

Collaboration on Clinical Pharmacy Initiatives

Pharmaceuticals increasingly dominate treatment approaches for most acute and chronic illnesses, and this trend is likely to intensify as more novel agents are approved for the marketplace. As a result, the relative importance of the current prescription drug programs

in both Departments is likely to grow, accounting for a greater share of the cost of care for beneficiaries. Therefore, it is crucial that the two Departments develop a coordinated pharmacy system to ensure benefit consistency throughout a service member's lifecycle, improve access to medications for veterans, provide effective safeguards against adverse drug events, and better manage pharmaceutical utilization and cost.

The PTF focused its assessment of VA/DOD clinical pharmacy issues on the need to develop a joint national, evidence-based core formulary with uniform screening systems and expert review.

Developing a Joint National Core Formulary

In 1999, the Transition Commission recommended that VA and DOD develop and deploy a joint national formulary in order to take advantage of economies of scale when jointly purchasing pharmaceutical products. To date, however, although departmental consideration has been given to the issue, no formal action has been taken.

VA and DOD maintain different formulary systems largely as a result of their disparate beneficiary populations, but also because they comprise two large health care systems with different decision-making processes. Perhaps the most significant barrier to creating a joint formulary has been the disparate systems currently employed within DOD: an MTF basic core formulary (BCF), which can be tailored to meet local medical needs; an unrestricted formulary in the retail environment; and a relatively unrestricted formulary through the TRICARE Mail Order Pharmacy (TMOP). The congressionally mandated DOD Uniform Formulary,⁶ however, will supplant these divergent formularies in the near future, perhaps offering further potential for combination with VA's national formulary.⁷

Through the BCF, DOD maintains a list of approximately 165 largely ambulatory pharmaceutical products that every MTF must stock and fill when requested. The Department has the ability through local Pharmacy and Therapeutics (P&T) Committees to augment the BCF to meet the unique or local medical needs of specific populations. In contrast, TMOP has few product restrictions, and the retail segment has none.

VA's National Formulary (VANF), like the BCF, is a required list of pharmaceutical products that every VA Medical Center (VAMC) must stock and provide when requested. The VANF is a list of roughly 1,200 line items, including nearly 500 ambulatory drug products. VISNs, like MTFs, are able to augment the VANF with products that meet

⁶ Public Law 106-65, National Defense Authorization Act for Fiscal Year 2000, Section 701.

⁷ A proposed rule outlining the framework for a uniform formulary marrying the three DOD formularies has been promulgated by DOD; to date, no final rule has been put forward. Seemingly, if a joint national formulary with VA were to be constructed, DOD would have to be relieved of its current statutory obligation, or VA would have to comply with DOD's Uniform Formulary.

their local medical requirements. Currently, however, local VAMCs cannot individually augment the VISN formulary, but there are processes available to provide medically necessary pharmaceuticals to veterans.

GAO referenced the PTF's work in this area and highlighted the potential utility that a joint formulary would bring to the Departments. Specifically, GAO noted that such a formulary could reduce the number of therapeutic alternatives within a drug class, facilitate provider education on formulary products, and decrease the number of therapeutic changes that could lead to adverse drug events as VA/DOD beneficiaries move among facilities and between Departments.⁸ Establishing a uniform formulary would likely minimize problems for veterans in transition between DOD and VA. The PTF believes that a joint national core formulary that provides for local flexibility would enhance the continuity of care for beneficiaries who access multiple points of pharmaceutical care within the two systems, and would likely provide additional opportunities for joint contracting between the Departments.

A joint national core formulary that provides for local flexibility would enhance the continuity of care for beneficiaries who access multiple points of pharmaceutical care within the two systems.

Need for External Expertise

Clinical drug reviews are a necessary component of formulary management. They are conducted routinely to determine which chemical entities within a therapeutic class exhibit the greatest efficacy, safety, and tolerability for the greatest number of beneficiaries. VA and DOD have developed in-house capabilities to perform clinical reviews and adjudicate formulary inclusion/exclusion decisions. Both Departments have institutionalized their pharmacy benefits management practices: VA through its Pharmacy Benefits Management Strategic Health Group (PBM) and DOD through its Pharmacoeconomic Center (PEC). Currently, the Departments are the only major federal entities that provide beneficiaries with prescription drugs outside of HHS and are the only bodies to act as both payer for the products on formulary and as the clinical review body absent any independent consultative mechanism.

Products considered for inclusion on the VA formulary are reviewed by the VISN Formulary Leaders and the Medical Advisory Panel (MAP)⁹ with clinical support provided

⁸ GAO, "Increased Risk of Medication Errors for Shared Patients" (GAO-02-1017), September 2002.

⁹ MAP provides physician-level oversight to the PBM on formulary issues and is comprised of VA physicians, a DOD physician, and PBM clinical staff.

by the PBM. Any addition to the formulary at the VISN level is reviewed by the VISN Formulary Committee.¹⁰ Though formulary decisions are made public, there is little opportunity for public comment prior to adjudication, and little opportunity exists for outside experts to participate in the process.

To ensure the effectiveness and objectivity of the formulary development process, VA and DOD should incorporate experts external to the Departments into their formulary management processes.

DOD's formularies are reviewed by P&T Committees at the national and local MTF levels. The BCF is reviewed and amended by the national P&T Committee with clinical support provided by DOD's PEC. Additions to the BCF at the local level are reviewed and approved by local P&T Committees and receive no further public or private scrutiny.

The PTF believes that in order to ensure the effectiveness and objectivity of the formulary development process, VA and DOD should incorporate experts external to the Departments into their formulary management processes. Once a joint formulary is developed, a joint review process should be created between the Departments that also incorporates experts from outside the government. Though little precedence exists for this type of blended clinical review, the Task Force believes that such an approach would largely ameliorate potential concerns over formulary exclusion decisions based solely on cost.

Developing a Single, Common Pharmaceutical Screening Tool

In 2002, GAO examined the need for a single, common system between the Departments to screen for potential drug-drug, drug-disease, and allergic reactions for VA/DOD shared patients. GAO recommended that VA and DOD implement an interoperable system to ensure complete checking for drug interactions based on full medication history, including prescriptions ordered through VA's Consolidated Mail Order Pharmacies (CMOPs) and TMOP.¹¹ GAO also recommended consideration of the Pharmacy Data Transaction Service (PDTS), an off-the-shelf commercial database administered by a private contractor that screens for drug-drug interactions and dosage errors, as a possible alternative.

Deployed system-wide by DOD in 2001, PDTS is intended for use in real time across all segments of the MHS—MTFs, TMOP, and TRICARE-contracted retail pharmacies.

¹⁰ New molecular entities have to first be reviewed and approved by the PBM before they can be added at the VISN level. Additionally, the ability to add products to the VISN formulary is limited to those not under a national, exclusive contract.

¹¹ GAO, "Increased Risk of Medication Errors" (GAO-02-1017), September 27, 2002.

The only points of service not accessible by PDTS are the non-TRICARE retail pharmacies sometimes used by DOD beneficiaries, a small percentage of overall pharmacy encounters.

In addition to monitoring potential adverse interactions, PDTS reliably captures all pharmacy encounters within the MHS (except those noted above) and allows DOD to query all prescriptions received by an individual patient or written by an individual physician.

At VA, the Veterans Health Information Systems and Technology Architectures (VistA) system is used to check pharmacy orders, including drug-drug interactions, drug-allergy interactions, and duplicate drug class orders. However, unlike PDTS, VistA is unable to perform this check outside the local facility where the prescription is filled. While VA's Computerized Patient Record System has a limited ability to access orders filled at other VA facilities, it lacks real-time functionality.

Neither Department has demonstrated substantial interest in using the other's clinical screening capabilities.

Neither Department has demonstrated substantial interest in using the other's clinical screening capabilities. Section 724 of the Bob Stump National Defense Authorization Act for Fiscal Year 2003 (Public Law 107-314) mandates that a collaborative solution be found for clinical drug screenings across the Departments' pharmacy systems by October 1, 2004. If the Departments fail to meet this deadline, PDTS must be fully deployed across both systems by October 1, 2005.

Recommendation 4.3

VA and DOD should integrate clinical pharmacy initiatives through the coordinated development of: 1) a national joint core formulary; and 2) a single, common clinical data screening tool by fiscal year 2005 that ensures reliable, electronic access to complete pharmaceutical profiles for VA/DOD dual users across both systems.

Streamline the Pharmacy Benefit to Meet Increased Demand

The recent rise in pharmacy demand has been exacerbated by the fact that VA has historically maintained tight control over prescriptions written by outside physicians/providers. The Department has required that all prescriptions written by non-VA physicians, including DOD providers, either be co-signed by a VA physician or re-written by a VA physician, sometimes for a different pharmaceutical product altogether (one conforming to VA's National or VISN Formularies). However, VA workload is being impacted

by a significant number of veterans with income above VA's means test threshold with no compensable service-connected conditions seeing a doctor only to have a prescription rewritten. The result is a backlog and long waits for veterans who need to see VA providers for all their health care.

Easing the backlog in access could be accomplished by allowing pharmacy services at both VA and DOD to fill prescriptions issued by either VA or MTF providers. Opening VA pharmacies to DOD beneficiaries would provide additional access at significant financial savings to DOD when compared to the use of retail pharmacies, and opening DOD pharmacies to VA beneficiaries would provide additional access with best federal pricing for pharmaceuticals.

Recommendation 4.4

VA and DOD should collaborate on policy and program changes, through local sharing arrangements, which would permit prescriptions written by either VA or MTF providers to be filled for dual users by the other Department's pharmacies.

There are costs and benefits of such collaboration, which must be considered in developing local plans. On the benefit side, this collaboration could: provide additional access points of service for VA and DOD beneficiaries; reduce VA provider workload for prescription-only visits; foster increased collaboration and improved access for veterans who are military retirees; and provide some additional revenue for the Departments. On the other hand, it is possible that this collaboration could create additional workload for the Departments, and require changes to or replacement of billing practices and systems.

Joint Contracting

Currently, very little of the billions of dollars spent each year by the two Departments on medical equipment, supplies, and IT flows through joint contracting vehicles. In the case of medical supplies, more than half are purchased locally, with little or no national or regional databases or controls. While this approach provides significant choice to providers, it also makes data collection, analysis, and efficiency problematic.

In 1999, the two Departments agreed to implement joint purchasing of pharmaceuticals and medical supplies and equipment. The goal was to achieve cost savings by combining VA/DOD purchasing powers in the marketplace. Joint contracting for pharmaceutical products for VA and DOD has received a great deal of attention in recent years and by

most accounts has resulted in significant savings or cost avoidance, reported by both Departments as totaling \$369 million in fiscal year 2002.

Despite this success, little has been accomplished with respect to joint contracting for supplies and equipment, or IT-related products. Several factors have contributed to this lack of action. These include:

- use of both local and centralized purchasing and distribution channels;
- use of multiple data sources for pricing and product identification; and
- lack of a uniform methodology to standardize items.

Clearly, any effective expansion of joint procurement will limit choices to local and regional providers. Thus, it is imperative that any such attempt be based on clinically-driven standards supported by peer-reviewed literature and research.

Acquisition of IT capabilities such as new systems, or commodities such as software, hardware, and communications, is also an area of significant opportunity. The cost, cycle time, and quality of the IT acquisition processes for both Departments are potential areas for improvement through collaboration.

Greater interdepartmental collaboration could result in the broader use of best acquisition practices, federal procurement schedules, and government-wide acquisition contracts. The combined market presence of VA and DOD creates significant potential for both Departments to achieve greater efficiencies and promote the use of data standards within commercial off-the-shelf products.

Both Departments have unique, mission-driven requirements that influence procurement decisions. DOD faces challenges with regard to rapid deployment and its demands on the supply chain. Therefore, any efficiencies attained through joint acquisition and procurement must accommodate this critical requirement.

There are numerous contract vehicles available to VA and DOD that allow for procurement across a wide range of goods and services. But in the acquisition of major health care commodities, the reality is that one size does not fit all, either within or between the two Departments, or among the commodities being purchased. Given this, options for joint contracting in each area are described separately below.

The combined market presence of VA and DOD creates significant potential for both Departments to achieve greater efficiencies and promote the use of data standards within commercial off-the-shelf products.

Building on the Success of Pharmaceutical Purchasing

The success in joint purchasing of pharmaceuticals between VA and DOD provides a model that could be adapted to other joint contracting opportunities. In fiscal year 2001, expenditures within VA and DOD for pharmaceuticals rose at a heightened pace, with VA growing at a rate of nearly 20 percent and DOD growing at roughly 28 percent. As a result of these rapidly increasing costs, and because Medicare lacks a comprehensive prescription drug benefit, increasing and conflicting pressures are mounting in VA and DOD to provide a robust but fiscally prudent pharmaceutical benefit.

The Departments have taken a number of important steps to improve pharmaceutical contracting operations and to leverage the significant purchasing power of VA and DOD, including: 1) development of an organizational structure to support joint contracting/purchasing; 2) combined use of VA's Federal Supply Schedule; and 3) increased diligence in the identification, pursuit, and evaluation of joint national contracts and other contracting opportunities.

Supplies and Equipment

Both Departments are implementing more centralized purchasing systems for supplies and equipment, although their approaches differ. Leveraging buying power is made more difficult because each Department uses different data collection and reporting systems for health care supplies and equipment. The lack of a single medical cataloging system prevents daily, real-time accessing and sharing of pricing data; thus, on-line shopping, price comparisons, and vendors are limited. It is important to note that this lack of a single system and nomenclature is an industry-wide problem, not specific to federal purchasers. This deficiency is well known throughout the medical supplies and equipment industry and attempts are underway to address the problem.

Recommendation 4.5

VA and DOD should work with industry to establish a uniform methodology for medical supplies and equipment identification and standardization and to facilitate additional joint contracting initiatives. VA and DOD should identify opportunities for joint acquisitions in all areas of products and services.

The Need for Interoperable IM/IT Systems

Information technology is a key enabler of many of the processes needed to achieve a seamless transition from military service to veteran status and to support VA/DOD collaboration.

In the past, each Department has developed its own IT systems to meet mission priorities, with little regard for areas of commonality and overlap. This has been due, in part, to a lack of joint strategic planning and business process re-engineering. Increased collaboration and IT interoperability can improve the process of transition from military service to veteran status, determination of veterans' benefits, and delivery of health care by allowing effective and efficient information exchange between DOD and VA.

VA and DOD have begun to define the policies and information exchange requirements to ensure the effective continuity of care for veterans. These policies need to be made more robust to support the development of requirements for a coherent suite of information systems. In particular, the Departments can enhance collaboration by:

- developing compatible information architectures;
- jointly adopting and implementing standards for messaging and communication, security and authentication, privacy and data protection, controlled medical vocabulary, and coding and classification; and
- establishing processes for joint IT product funding, acquisition and development, delivery, and maintenance, as well as effective collaboration on existing and emerging technologies.

Effective interoperable or joint IT solutions that significantly improve VA/DOD collaboration can be more readily achieved when there is senior executive commitment to strategic planning, synchronized resources and policies, motivation at all levels of management, and accountability. Senior leadership must also ensure that the highest priority items receive the most attention and are appropriately funded.

Increased collaboration and IT interoperability can improve the process of transition from military service to veteran status, determination of veterans' benefits, and delivery of health care by allowing effective and efficient information exchange between DOD and VA.

A sustained commitment to developing interoperable IT systems that support or enable reengineered processes will be critical to many aspects of VA/DOD health care delivery.

The interagency leadership committee has begun to address the need for greater IT systems interoperability. The interest and activity level of this committee appear to be strong, although continuity of effort could be affected by changes in personnel and administrations. A sustained commitment to developing interoperable IT systems that support or enable reengineered processes will be critical to many aspects of VA/DOD health care delivery.

Recommendation 4.6

The interagency leadership committee should identify those functional areas where the Departments have similar information requirements so that they can work together to reengineer business processes and information technology in order to enhance interoperability and efficiency.

Facility Lifecycle Management

The VA and DOD health care systems together comprise approximately 250 hospitals and medical centers and 1,400 ambulatory care facilities. In total, these facilities encompass almost 200 million square feet of space, and represent \$50 billion in plant replacement value (PRV). The average age of VA inpatient facilities is over 53 years. Approximately 43 percent of the MHS facility inventory is less than 25 years old and 42 percent is 25-to-50 years old. Most of VA's, and to a lesser degree DOD's, facilities were constructed based on the assumption of large inpatient populations. An aging population, vast technology improvements, and the trend toward less invasive practices and more ambulatory services are influencing how existing and new health care facilities adapt and operate.

Approximately \$1.1 billion is invested annually in the VA and DOD physical infrastructure for new construction, maintenance, and major repairs. This funding level is approximately one quarter of the generally accepted minimum investment level for health care facilities.¹² VA's health care facility infrastructure is grossly undercapitalized. Major and minor construction from 1996 to 2001 averaged only \$246 million annually, representing a recapitalization

¹² *Final Report, Independent Review of Office of Facility Management*, Price Waterhouse, June 17, 1998, and *Final Report, Military Health Services System Facility Lifecycle Management - Investment Strategy and Maintenance Cost Model*, VW International, December 31, 1996. See also *Medical Facility Life Cycle Investment Strategy*, American Society of Healthcare Engineering, Healthcare Facilities Management Series, 1997, and *Committing to the Cost of Ownership*, Federal Facilities Council, National Research Council, 1990.

rate of .64 percent of VA's \$38.3 billion total PRV. At this rate, VA would recapitalize its infrastructure every 155 years. When maintenance and restoration are considered with major construction, VA invests less than 2 percent of PRV for its entire facility infrastructure. DOD invests approximately 3.5 percent of PRV across all investment categories. A minimum of 4 to 8 percent investment of PRV is necessary to maintain a healthy infrastructure.¹³

DOD's current health care facility acquisition and maintenance process suffers from an overly complex set of business rules and the sequential nature of its traditional planning process. Moreover, the planning process is highly regulated, both internally by DOD's health care facility planning policies, and externally by Congress. Planning requirements are locked in so early that critical planning assumptions are generally not valid by the time operations commence. Assumptions surrounding population demographics, clinical mix, and utilization rates traditionally have been overstated. DOD's experience with facility lifecycle management has been one of long planning, design, and construction cycles that result in overbuilt inpatient facilities, insufficient ambulatory space, and design and construction methods that are more relevant to outmoded health care delivery systems.

Within VA, areas needing improvement include developing systematic and programmatic linkage between major construction and other lifecycle components of maintenance and restoration. VA does not have a strategic facility focus, but instead submits an annual "Top 20" facility construction list to Congress; by contrast, DOD submits a six-year major capital projection annually. Within the current statutory and business rules, VA can bring new facilities online within four years. However, VA facilities are constrained by reprogramming authority, inadequate investment, and lack of a strategic capital-planning program.

The PTF believes that VA and DOD must accomplish three key objectives: 1) invest adequately in the necessary infrastructure to ensure safe, functional environments for health care delivery; 2) "right size" their respective infrastructures to meet projected demands for inpatient, ambulatory, mental health, and long-term care requirements; and 3) create abilities to respond to a rapidly-changing environment using strategic and master planning to expedite new construction and renovation efforts.

VA and DOD must invest adequately in the necessary infrastructure, "right size" their respective infrastructures, and create abilities to respond to a rapidly-changing environment.

¹³ Ibid.

The first step is to align business rules and processes focused on facilitating meaningful collaboration between the two Departments by:

- identifying future capital construction project five to six years in the future;
- committing to seek sufficient funding to support an appropriate rate of investment in medical infrastructure; and
- continuing to align the two Departments' space and functional criteria. In addition, DOD should adopt a capital-planning model, similar to VA's, that will allow for a coherent process to identify capital requirements, determine the relative value among requirements, and facilitate capital decisions that support departmental goals.

The second step is to address statutory and regulatory barriers, including: DOD's 35-percent design requirement for medical construction prior to submission to Congress; VA and DOD's different dollar thresholds for minor and major construction and construction reprogramming; and DOD's requirement to use specific design and construction agents for military construction.

The third step is for VA and DOD to develop a facilities lifecycle institutional knowledge capacity focused on leveraging governmental and commercial best practices. Private sector facilities tend to be in a constant state of planning and execution, responding to market and technology changes and adjusting capital programs. Thus, design and construction changes are routinely made as late into the program as possible to allow for shifts in the external environment. In the private sector, strategic planning generally focuses on a five-year horizon, with facility master planning conducted every three years, and revalidation of planning assumptions conducted every three years. VA and DOD should jointly adopt commercial and government facility lifecycle management best practices. Through the Capital Asset Realignment for Enhanced Services (CARES)¹⁴ and the Base Realignment and Closure (BRAC)¹⁵ processes, VA and DOD should collaborate to identify underutilized and excess facilities to better correlate health care demand with the quantity and mix of infrastructure.

¹⁴ CARES is a restructuring process that aligns infrastructure to projected demand, provides a rational framework for decision making, and emphasizes communication with all stakeholders.

¹⁵ DOD has significantly reduced its infrastructure under the authority of the Defense Authorization Amendments and Base Closure and Realignment Act (Public Law 100-526), and the Defense Base Closure and Realignment Act of 1990 (Public Law 101-510). In the context of medical facilities alone, BRAC has resulted in a reduction of 48 hospitals within the U.S. and abroad (approximately 40 percent of 1988 infrastructure), as well as over 400 clinics and 45 hospital-to-clinic realignments.

Recommendation 4.7

VA and DOD should implement facility lifecycle management practices on an enterprise-wide basis. This should be accomplished by aligning business rules, eliminating statutory barriers, and adopting best practices.

Joint Venture Sites

At the direction of Congress, VA and DOD have developed a number of joint venture sites to promote collaboration and conserve resources. These sites have been created as exceptions to the rule, rather than as test sites for new policies, practices, and products that may be used for Department-wide implementation.

By design and of necessity, joint venture sites vary greatly in characteristics, including geographical constraints, physical plant, operations, extent of integration, availability of resources, and approach to command and control. There are seven official joint venture sites, wherein VA and DOD have collaborated on capital investment and operation of newly constructed facilities (see Table 4.1). In some cases, a more integrated facility was constructed that allowed for greater interoperability, at least for direct patient care services. In many instances, however, duplicative facilities for administrative and expensive high-technology ancillary services were constructed and operate separately, minimizing the overall value of the collaboration.

Table 4.1 Official VA/DOD Joint Venture Sites

Albuquerque, New Mexico	– New Mexico VA Health Care System and the 377th Air Force Medical Group (Kirtland AFB)
Anchorage, Alaska	– Alaska VA Healthcare System and Regional Office and the 3rd Medical Group, Elmendorf Air Force Base
El Paso, Texas	– El Paso VA Health Care System and William Beaumont Army Medical Center
Fairfield, California	– Fairfield VA Outpatient Clinic, part of the VA Northern California Health System, and David Grant Medical Center, Travis AFB
Honolulu, Hawaii	– Spark M. Matsunaga VA Medical & Regional Office Center and Tripler Army Medical Center
Las Vegas, Nevada	– Mike O’Callaghan Federal Hospital - VA Southern Nevada Healthcare System and Nellis Air Force Base, 99th Medical Group
Key West, Florida	– The Navy (Jacksonville Naval Hospital) and VA (VA Medical Center Miami) co-occupy an outpatient care facility

Other than the DOD health facility planning guidance outlined in the Military Health System Medical Facilities Life Cycle Management Strategic Plan, issued in April 2002, VA and DOD have not established comprehensive policies with respect to joint venture sites. Moreover, the separate strategic planning and management practices, personnel assignment processes, and standard IT capital investment programs of each Department generally have disregarded the needs of joint venture sites. Therefore, these sites have operated largely in an ad hoc manner without a formal policy framework to assist local or chain-of-command decision-making. On a positive note, the Office of the Assistant Secretary of Defense (Health Affairs) Facilities Management Director included in the April 2002 Strategic Plan policy guidance that requires coordination with VA when developing requirements for capital military construction projects. However, additional leadership via the interagency leadership committee is needed.

Recommendation 4.8

VA and DOD should declare that joint ventures are integral to the standard operations of both Departments. Through the interagency leadership committee, the Departments should articulate policy requiring that:

- 1) all major initiatives of each Department be designed and tested for effectiveness and suitability in joint venture sites;**
- 2) lessons learned from successful joint ventures be shared with other joint venture sites and also throughout the health care delivery systems of the two Departments;**
- and 3) all proposed VA and DOD facility construction within a geographic area be evaluated as a potential joint venture.**

Human Capital and Credential Review

Health care delivery is labor-intensive, requiring highly trained personnel. Two pressing issues will shape DOD's and VA's ability to collaborate in the recruitment, hiring, and sharing of medical personnel: commonality and consolidation of personnel management systems, and mutual recognition of credentialing practices.

Personnel Management Issues

In a tight labor market, the natural response to a personnel shortage is to raise incentives to attract and retain needed personnel. Incentives may include increases in direct compensation, retention and signing bonuses, and improved benefit packages. VA and DOD have significantly different personnel management systems for civilians. Civilian personnel policies under title 5, U.S. Code, govern DOD, while VA operates under title 38, U.S. Code, for most of its health care personnel. Under title 5, flexibility to meet market changes and competition for scarce civilian personnel resources is not as great as under title 38. For example, DOD can go to special civilian salary rates only after wage surveys have been completed and there is proof of inability to hire. Under title 38, VA has multiple local compensation options, which makes it more competitive than DOD in the marketplace. VA can pay more, offer work schedule options not permitted under title 5, and recruit faster.

VA and DOD have significantly different personnel management systems for civilians.

Congress has recognized this disparity and, through provisions in annual DOD Appropriation Acts, has given DOD title 38 authority for health care professionals. In turn, the Office of Personnel Management (OPM) has given DOD a number of authorities available under chapter 74 of title 38 through June 30, 2012, for jobs involving medical skills.

In early fiscal year 2003, title 38 authority was delegated to the Services, including pay, hours of work, and qualification-based grading authorities—all of which can help recruit and retain civilian medical personnel. To be effective, however, these authorities need to be further delegated to the commanders of medical and dental facilities. For a local activity to use these authorities, the Defense Finance and Accounting Service (DFAS) would have to modify its accounting procedures to accommodate the flexibilities provided under title 38. For example, title 38 is based on a 2,080-hour work year while title 5 is based on a 2,087-hour work year. This seemingly minor difference must be reconciled to calculate pay and leave accrual to achieve title 38 flexibilities. Some of the premium pays allowed under title 38 are also not supported under title 5 and will need to be built into the DFAS information system.

Currently, there is a mandate that federal government payroll systems be consolidated. The DFAS system was one of four systems selected for other departments to use in consolidation. The VA system was not selected. OPM has tentatively scheduled VA to convert to

the DFAS system to meet its payroll needs. If VA ultimately converts to the DFAS system, reprogramming to meet DOD's medical use of the title 38 authority will be facilitated.

In addition, the two Departments might work at the local, regional, and national levels to share, jointly hire, or loan personnel resources to optimize efficiency. With critical shortages of health professionals projected into the near future, additional opportunities might be available at VA and DOD policy-making levels to identify joint solutions to staffing problems. For example, a growing body of evidence suggests that collaborative practice between physicians and non-physician providers (including clinical pharmacists and others) often can decrease pharmacy costs through aggressive management of therapeutic alternatives, elimination of redundant prescriptions, and reductions in adverse drug events.¹⁶ These non-physician providers help reduce health care costs and access times by delivering care to specific patient subsets within their respective scopes of practice.

The implementation of local scopes of practice that allow non-physician providers a certain amount of autonomy in managing patient care is not foreign to either VA or DOD. All three Military Departments have promulgated guidelines for non-physician providers, but they are not identical. VA has separate practice guidelines for non-physician providers. The somewhat disparate nature of these guidelines handicaps uniform scopes of practice at the local level and undermines access of veterans, including military retirees, to a consistent, reliable pharmaceutical and disease management resource.

Redundancies in Credential Review of Health Care Providers

VA and DOD policy and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) preclude health care providers from providing health care independently in JCAHO accredited facilities until they have been approved for privileges. Each facility has a credentials committee or coordinator responsible for reviewing providers for licensure, relevant training and/or experience, competence, and health status. The reviewer forwards recommendations to the designated privileging authority, which then grants delineated clinical privileges. Such privileges must be renewed in this manner at least every two years. The credentialing process requires extensive verification of primary source documentation, such as the school that provided the education and training, the state that issued the license, and clinical history, before clinical privileges can be granted to any health care practitioner.

¹⁶ Bond, C.A., Raehl, C.L., Franke, T. "Interrelationship among mortality rates, drug costs, total cost of care, and length of stay in United States hospitals: summary and recommendations for clinical pharmacy services and staffing." *Pharmacotherapy* 2001; 21(2):129-141.

An official in each facility maintains credentials files with all primary source documentation for every provider in a given facility from the time the provider becomes a staff member or begins to work in a consultant or attending position. The files are available for review by accreditation officials and agencies at the time of accreditation visits.

The DOD Clinical Credentialing Quality Assurance System is a secure database, developed by the Navy Medical Department and now implemented worldwide on a tri-departmental basis. It provides automation support to the management of credentials and additional pertinent material and related actions. It has been approved by JCAHO as a solution for electronic transfer of primary source verified credentialing data and other related material. It is complementary to, but not yet interoperable with, VA's automated credentials system, VETPRO, which accomplishes essentially the same functions within VHA.¹⁷ The Departments are working together to develop an interface between the two systems which they will pilot in the current fiscal year (2003) to support reengineered credentialing processes.

VA and DOD policies require that a provider currently privileged at a VA facility who desires clinical privileges at a DOD facility (or vice versa) must essentially repeat the entire process for primary source verification of credentials within the other Department's system before privileges can be granted.

Such duplication of effort wastes time, effort, and resources, creates frustration, and occasionally engenders animosity with little or no demonstrable value added. Although each Department has a mechanism for transferring and accepting primary source verified information among its facilities, both Departments appear reluctant to accept the other's data to facilitate and expedite the granting of provider privileges. Neither Department has the ability to electronically view or send credentials information to the other. Other key issues that seemingly impede further cooperation in the verification of credentials include: 1) concerns that one process or the other is more rigorous; and 2) that JCAHO may cite the organization for failure to carry out a primary source verification of the credentials on which it based its privileging decision.

¹⁷ VETPRO was developed in collaboration with the Department of Health and Human Services and other federal agencies through the Federal Inter-Agency Credentialing Initiative.

Recommendation 4.9

VA and DOD should work together to identify and address staffing shortfalls, develop consistent clinical scopes of practice for non-physician providers, and ensure that their provider credentialing systems interface with each other.

The Departments should ensure JCAHO approval of their mechanisms for transmitting verified credentials information between facilities. It might be necessary to develop a Memorandum of Understanding to disseminate such a practice across VA and DOD.

Summary

Significant institutional barriers to collaboration arise from the ways VA and DOD—and the three Military Departments—develop and deploy their resource plans. These include the budgeting process, health care delivery plans, acquisition plans, and facility plans. Different time frames, requirements, definition processes, methodologies, standards, and resource allocation models also increase the complexity of collaboration.

As a result, collaboration occurs most often in an ad hoc manner in the field—despite the institutional processes, rather than because of them. To address this problem, VA and DOD should work to identify the greatest opportunities to align planning methods, business practices, funding timetables, and other major institutional differences. The aim is to determine the potential for joint standards and programs that will increase cost-effectiveness. The PTF is optimistic that recent attention to the need for a strategic planning process will help the two delivery systems deliberately plan for interoperability and cost savings, and that the issues and recommendations in this chapter will provide the interagency leadership committee with potential future objectives.

CHAPTER FIVE

**Timely Access to
Health Services and the
Mismatch between
Demand and Funding**

CHAPTER FIVE

Timely Access to Health Services and the Mismatch between Demand and Funding

Access to health care is important to all Americans. It is especially important to and deserved by those who have served in the Armed Forces and suffered injuries as a result or who later experience health problems associated with their service. However, many of those who have made the commitment to defend our country have not always received fair, equitable, or appropriate access to health care once their military service is completed. The Federal Government has been more ambitious in authorizing veteran access to health care than it has been in providing the funding necessary to match declared intentions. Based on PTF site visits and information provided by VA and veterans service organizations, there is persistent concern about the inability of VA to provide care to enrolled veterans within its established access standards. Although enrolled veterans theoretically have access to the VA health care system, in reality long waiting times for appointments with health care providers continue to be a problem for a significant number of enrollees.

Chapters 3 and 4 of this report focus on the need to increase sharing and other collaborative efforts between VA and DOD and on the need for productivity improvements. Despite the importance of these efforts, it became apparent to the PTF that increased collaboration and sharing alone cannot improve access because neither system has sufficient excess capacity. Collaboration might help facilities in some areas overcome modest or temporary capacity shortfalls or surges in demand, and standardization and compatibility of information systems and medical records between VA and DOD will provide lasting improvements in health care delivery to veterans. However, the apparent mismatch between demand for access and available VA funding to meet this demand is too large to be solved by collaboration and sharing alone.

The apparent mismatch between demand for access and available VA funding to meet this demand is too large to be solved by collaboration and sharing alone.

In recent years, with the entrance of the former Priority Group 7 veterans into the system, many veterans in Priority Groups 1 through 6 have been unable to obtain health care within VA's established access time frames (see Box 5.1 and Appendix F for more information on priority groups). This situation, in which the traditional users of the VA health care system—veterans with service-connected conditions and indigent veterans—must wait a long time for appointments and care, is unacceptable.

In this chapter, the PTF makes recommendations on ways to ensure full funding for the comprehensive benefit for Priority Groups 1 through 7 (new) within VA's access standards and emphasizes the need to clarify and address the status of Priority Group 8 veterans.

The Growing Mismatch Between Funding and Demand

In the past seven years, a number of events have coincided to create the current mismatch between demand for VA health care and funding. Some have been external to the VA system (see Box 5.2), and others have been a direct result of legislative and administrative actions.

Box 5.1 New Enrollment Priority Groups

Under law, VA assigns enrolled individuals to one of eight priority groups, with the highest priority given to veterans who have the most serious service-connected disabilities (see Appendix F for a description of priority groups). One of VA's historical missions is to treat indigent veterans. To meet the needs of this constituency, VA classified as Priority Group 5 those veterans with non-service connected disabilities and incomes below VA's established means test threshold (\$24,644 for a single veteran and \$29,576 for a veteran with one dependent). Veterans in this group are not required to pay for health care. However, Congress was also concerned about those veterans living in high-cost areas and earning only marginally more than the threshold. Although categorized as Priority Group 7 veterans, it was evident that these individuals needed relief to cushion the effects of required co-payments. As a result, in January 2002, the President signed the Department of Veterans Affairs Health Care Programs Enhancement Act of 2001 (Public Law 107-135), creating a new category of veterans that acknowledges the high costs of living in many parts of the United States.

To implement the law, VA created two new priority groups to replace the old Priority Group 7. Veterans in the new Priority Group 7 must have incomes that exceed VA's national income threshold, but are below a geographically-adjusted means test—an income level set by the U.S. Department of Housing and Urban Development for over 3,000 counties across the country. This redefined Priority Group 7 qualifies for a reduction in co-payments. The new Priority Group 8 veterans are those with incomes either at or above the new geographic means test threshold. According to VA, about one-third of the former Priority Group 7 veterans will remain in the redefined Priority Group 7 and the remainder will be moved into Priority Group 8.

On the legislative front, two significant events have expanded the breadth and depth of the VA health care program. First, the Veterans' Health Care Eligibility Reform Act of 1996 (Public Law 104-262, hereinafter the Eligibility Reform Act) expanded the population of veterans who might receive VA care by allowing veterans to enroll whose incomes are above the established VA means test threshold and who do not have compensable service-connected conditions. Rather than create a new entitlement, Congress granted VA the authority to limit the population that could be enrolled in a given year and thus the means to stay within its annual appropriation.

In addition, the law greatly expanded access to outpatient care. Prior to 1996, most veterans were not authorized outpatient care unless they had recently been discharged from an inpatient setting or had a significant service-connected disability. Through this change, along with other actions to eliminate barriers to access—particularly access to primary care through the creation of more than 600 Community-Based Outpatient Clinics—VA intended to provide more care to more veterans, with the additional goal of increased cost-effectiveness. Other structural changes in VA's resource allocation methodology also have affected access and demand since the passage of the Eligibility Reform Act (see Box 5.3).

As required by the Act, to ensure that all enrolled veterans have access to the same level of health care, VA developed a comprehensive and uniform benefits package¹ that is offered to all enrollees, thus institutionalizing a comprehensive benefits package for

Box 5.2 VA Health Care in a Changing Environment

The increased demand for VA services is set against a backdrop of changes in the overall health care system. The shift from inpatient to outpatient care has made new demands on infrastructure and resources, while the increased use of expensive technologies and pharmaceuticals has added significantly to costs. In addition, since the late 1990s, premiums for employer-based health care coverage have increased steadily, and a growing number of employers are responding by shifting some of that cost to their employees (Henry J. Kaiser Family Foundation, May 2002). In some cases, costs have risen as benefits decreased (Kaiser/Hewitt Survey, 2002), while in others, employers have eliminated or reduced retiree benefits. These trends are likely causes of the increasing number of veterans (particularly in the former Priority Group 7) seeking health care from VA. Another likely factor is the absence of an outpatient pharmacy benefit under Medicare; this component of demand could shift if and when Medicare provides an outpatient drug benefit. As a public institution, VA has greater difficulty in adjusting to this changing environment than its private sector counterparts. Many of VA's responses require legislative or regulatory changes and because of the nature of annual appropriations, long-term planning is difficult.

¹ VA's health benefit package provides outpatient medical, surgical, and mental health care, including care for substance abuse, inpatient hospital care, and prescription drugs; benefits also include over-the-counter drugs and medical and surgical supplies.

Box 5.3 The Veterans Equitable Resource Allocation System

Since 1997, VA has used a capitated budget model known as the Veterans Equitable Resource Allocation (VERA) system to allocate to its 21 VISNs the health care budget appropriated by Congress. This system was designed to reflect changes in veteran demographics and geographic distribution over time as well as regional differences in health care needs and costs. VERA periodically adjusts allocations based on these factors as well as projected demands based on enrollment. Reviewers have generally concluded that VERA is fairer than the previous practice of allocating funds to VA facilities based on their historical expenditures or bed levels (GAO, February 28, 2002 and RAND, September 2002). However, the mismatch between demand and resources within VA is exacerbated by the fact that the VERA system distributes resources based only on Priority Groups 1 through 6 enrollee workload.

The VERA system omits explicit funding for Priority Groups 7 and 8, in part because VA anticipated that first- and third-party collections would cover a significant part of the cost of care provided to these veterans. However, revenues to date from these sources only cover approximately 24 percent of the associated costs. Since July 1997, facilities have been allowed to offset the costs of delivering care by retaining collections from third-party reimbursements, co-payments, per diems, and certain torts. However, because projected collections are incorporated into the budget calculation, the request for appropriated funds is reduced, thereby nullifying any net gain.

VERA provides a financial incentive for each VISN to increase enrollments, thereby increasing demand. In addition, VA's CARES program, which realigns future investment dollars to ensure appropriate infrastructure coverage across the country, requires that VISNs prepare gap analyses and demand projections based on enrollments and users. Thus, CARES serves as another internally driven incentive to increase enrollment and users, and thus, future demand.

the first time. Enrollees are eligible for any medically needed care or services that will promote, preserve, or restore health—regardless of whether or not the condition is service-connected.

Further expanding the benefit in 1999, the Veterans' Millennium Health Care and Benefits Act (Public Law 106-117) mandated new benefits for certain veterans, including both non-institutional and institutional long term care, and emergency care in non-VA facilities in certain situations.

Between October 2001 and September 2002, VA enrolled 830,000 new veterans, resulting in an unprecedented surge in demand for health care services. This trend is expected to continue, absent change in eligibility for enrollment,² exceeding VA's capacities for both primary and specialty care.

There has long been a tension between demand for VA services and the funds available under discretionary appropriations. This tension has increased in recent years as appropriators have been bound by a ceiling on discretionary spending. This means Congress could increase funding for care for veterans only if it reduced funding for other discretionary programs. In a world in which what is demanded and what is funded are

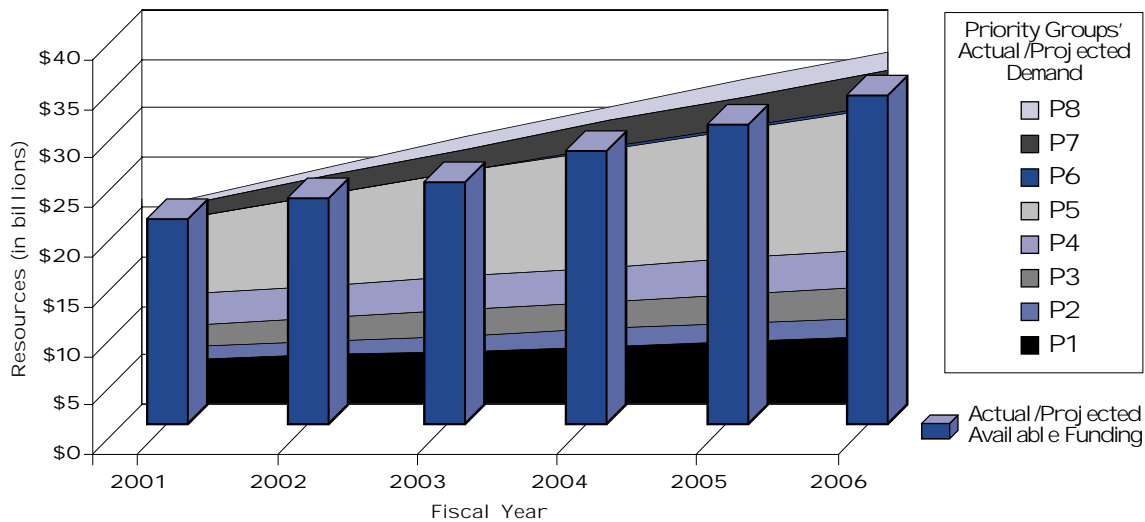
² As noted earlier, effective January 17, 2003, VA stopped enrolling Priority Group 8 veterans.

seldom the same, VA's ability to limit enrollment has been the equilibrating mechanism to reduce any mismatch.

Under the Eligibility Reform Act, when annual funding is not sufficient for VA to furnish the benefit to all veterans within the access guidelines it has established for itself, the Secretary has the authority to decide on an annual basis whether VA will continue offering enrollment to veterans in all priority groups. In the past, the presumption has been that enrollment would be available to VA's traditional constituency, those veterans in Priority Groups 1 through 6. Historically, however, VA's obligation authority has not supported demand and is not likely to do so in the future without a resolution of the mismatch between funding and demand (see Figure 5.1).

Figure 5.1 VA Resources vs. Demand

(Projected demand is exceeding actual/projected available funding even with a projected 10% annual increase over FY 2004 for FY 2005 and FY 2006)



Source: VA Model Estimates in September 2002

Although it has been theoretically possible to make funding meet demand, in reality political difficulties have prevented it, and have resulted in increased waiting times for enrolled veterans.

Despite the funding shortfall, until very recently, enrollment remained open for all Priority Groups since the enactment of the Eligibility Reform Act. Thus, although it has been theoretically possible to make funding meet demand, in reality political difficulties have prevented it, and have resulted in increased waiting times for enrolled veterans. Yet timely access is essential to meeting patient care needs, encouraging patient compliance with prescribed treatment, and ensuring continuity of care.

Because of the continuing large number of Priority Group 8 veterans³ seeking care, on January 17, 2003, the Secretary for the first time invoked the enrollment authority and prohibited any additional enrollment of the newly created Priority Group 8 veterans. An alternative would have been to continue enrolling all veterans and maintaining them on a space-available waiting list for appointments. As of January 2003, at least 236,000 veterans were on a waiting list of six months or more for a first appointment or an initial follow-up. In carrying out the enrollment level decision, the Secretary clearly indicated the unacceptability of adding to the waiting list, as it negatively affects the timeliness and thus the quality of patient care.

Background on the Changing Nature of the VA Health Care System

VA's overall mission is to serve all veterans through a variety of benefits and services. However, the Nation's historic health care commitment to veterans has been to care for the wounds of war and other service-connected disabilities. The VA hospital system was created to fulfill that obligation. Having created a network of hospitals, it made sense to use these facilities to care for non-service-connected illnesses in indigent veterans when space was available. Thus, over time VA increasingly was providing care for non-service-connected conditions for indigent veterans. As American medical care has moved rapidly from hospitals into the outpatient arena over the last two decades, VA responded by downsizing its underutilized inpatient facilities. Veterans above the means test without compensable service-connected conditions were first added on a resource-available basis for inpatient care in 1986 (with the requirement that they pay a portion of their care), and initially comprised about two percent of patients. By 2002, these veterans, who were by then eligible for all care, represented 24 percent of VA's patients.

³ As explained in Box 5.1 and Appendix F, new Priority Group 8 veterans are those veterans without compensable service-connected conditions whose incomes are above a geographically-adjusted means test. The group consists of approximately two-thirds of the former Priority Group 7.

In recent years, the combined effect of these and other factors has resulted in a large increase in demand for VA health care services, despite the fact that the overall veteran population has been declining and is projected to continue to do so.

Under the Eligibility Reform Act, all veterans are required to enroll for VA care, unless they have a disability rated at 50 percent or greater or are seeking care only for their service-connected disability. The requirement for enrollment was based on VA's need to know and be able to project the size of the population seeking care. In congressional hearings on legislation that led to the Act, VA officials also asked for the enrollment requirement to ensure that VA providers were adhering to statutory criteria, to provide a mechanism by which VA headquarters could hold field management accountable, and to allow VA leadership to design a more efficient system of care, within access standards and in anticipation of projected enrollments and the types of benefits veterans might be seeking.⁴

VA Access Standards

VA has had access standards since 1995 but has not been required to meet them. According to VA's fiscal year 2003 Performance Plan, a priority goal is to provide access to primary care appointments and specialty care appointments within 30 days of the desired date, with patients being seen within 20 minutes of their scheduled appointment. However, when an enrolled veteran seeks an appointment, VA has no obligation under current law to provide care within a specified time frame. VA's inability to provide veterans with a timely appointment in its own facilities also does not obligate it to purchase services from the private sector, as is the case for DOD enrolled beneficiaries in TRICARE, who are able to seek care in the civilian community when access standards cannot be met. Although VA may purchase private sector fee-for-service care for certain veterans in limited situations,⁵ it cannot purchase care solely because of access issues, such as long waiting times. In addition, VA generally has been reluctant to become a purchaser, rather than a provider, of care.

VA's inability to provide veterans with a timely appointment in its own facilities also does not obligate it to purchase services from the private sector, as is the case for DOD enrolled beneficiaries in TRICARE.

⁴ Statement by Kenneth W. Kizer, M.D., Under Secretary for Health, Department of Veterans Affairs, before the Committee on Veterans' Affairs, U.S. Senate, May 8, 1996.

⁵ VA can purchase fee-for-service care for certain veterans when it determines that it cannot economically provide a needed service, that VA care is geographically inaccessible, or that the illness/debility of a patient makes travel difficult.

Changes in the Benefits Sought by Veterans

According to a November 2002 General Accounting Office (GAO) report,⁶ of the \$3 billion VA spent on outpatient pharmacy drugs in fiscal year 2001, 13 percent of the total cost, or \$418 million, was for former Priority Group 7 veterans. Other surveys have also suggested that former Priority Group 7 veterans are significantly affecting VA's pharmacy workload,⁷ and anecdotal evidence suggests that many of these veterans are coming to VA only for prescription drugs. The GAO study reported that in fiscal year 1999, 400,000 of the former Priority Group 7 veterans had 11 million prescriptions filled. In fiscal year 2001, the number of veterans in this group seeking prescription drugs increased to 800,000 and the number of prescriptions filled grew to 26 million.

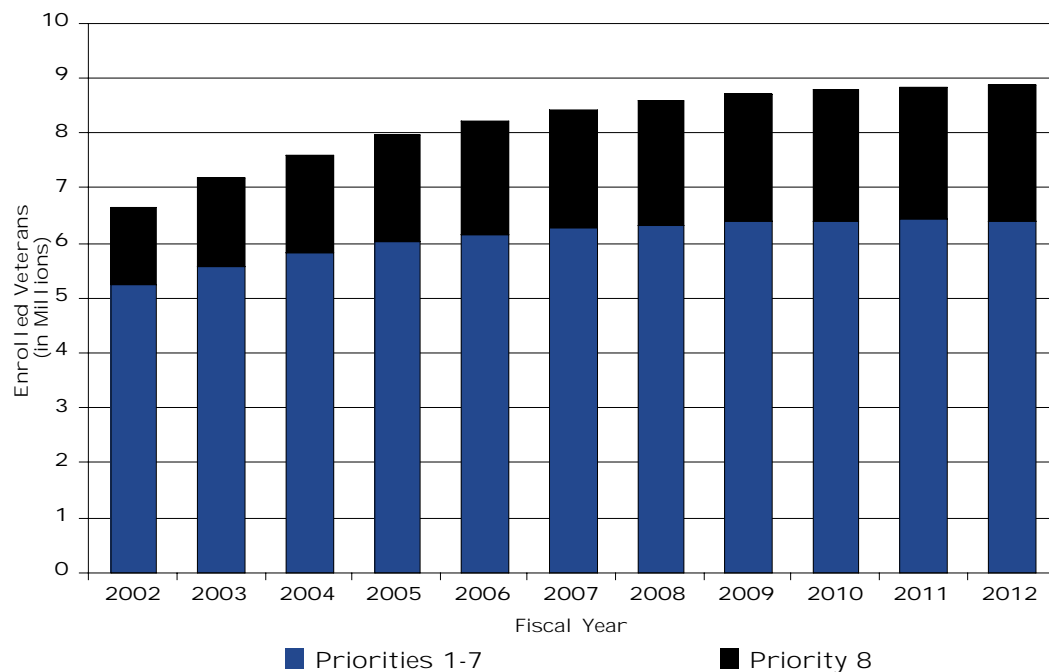
Projected Enrollments

While the overall number of veterans eligible for care in VA facilities is projected to decrease over the coming years, the actual number of beneficiaries seeking VA care has increased and is projected to continue growing. Since 1999, the number of VA enrollees has increased nearly 20 percent annually from 4 million enrollees to a current enrollment of 6.3 million. In 1999, veterans totaled nearly 26 million; in 2012, the projected number is 20 million. Based on VA's projection model, without any limitation on enrollment, enrollment will peak in FY 2012 at approximately 8.9 million enrollees. While enrollments were increasing in all priority groups, the group experiencing the largest and fastest growth was the former Priority Group 7—those veterans without compensable service-connected disabilities whose income is above VA's means test threshold. This group grew from 600,000 in fiscal year 2000 to 2 million in fiscal year 2002, and is projected to reach 3 million by fiscal year 2007. By fiscal year 2012, VA projects that Priority Group 8 veterans will constitute 27 percent of all enrollees (see Figure 5.2).

⁶ GAO, "VA Health Care: Expanded Eligibility Has Increased Outpatient Pharmacy Use and Expenditures" GAO-03-161, November 8, 2002.

⁷ VA conducted surveys in both 1999 and 2001 to identify the number of beneficiaries utilizing VA facilities for prescription-only visits. The results suggest that former Priority Group 7 veterans were exerting the greatest pressure on VA pharmacy, with between 30 and 38 percent of the veterans in the group using VA for the pharmaceutical benefit.

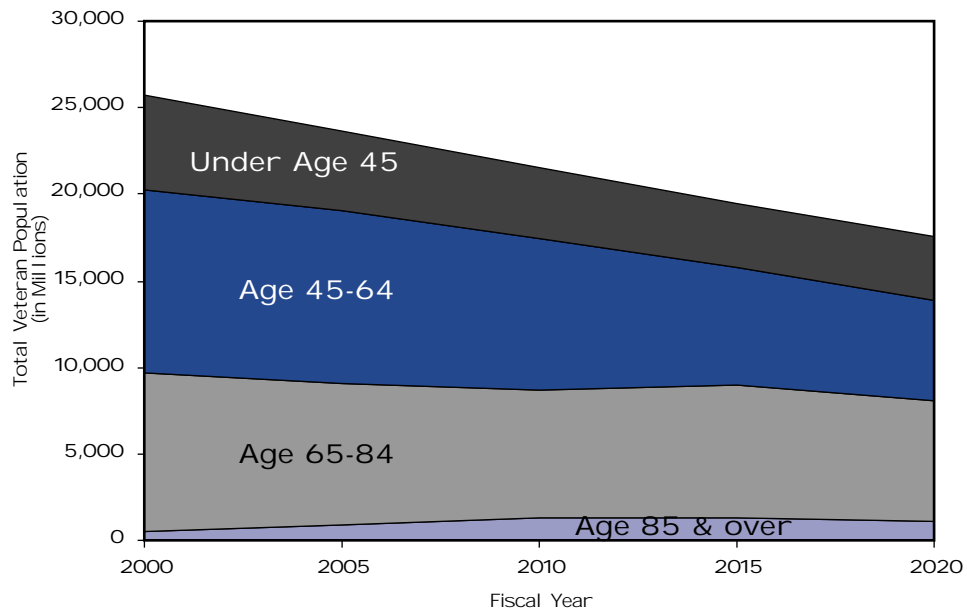
Figure 5.2 Enrollment Projections (FY 2002–2012)



An additional trend affecting future costs of care is the aging of the veteran population, with the number of veterans age 65 or over peaking in 2013 and veterans age 85 or over increasing by 130 percent between 2000 and 2020 (see Figure 5.3). The growth in the elderly veteran population, combined with their heavy use of pharmaceuticals—which are also consuming greater shares of the federal health care dollar—foretells rising costs of care.

Figure 5.3 Veteran Population: Age Trends, 2000–2020

(The total veteran population will decrease by 32% between 2000 and 2020)



VHA Office of Policy & Planning, Data Source: Vet Pop 2001

Recommendations for Addressing the Mismatch

The PTF considered various questions in addressing the mismatch in VA between demand and available funding, including:

- 1) Should Congress provide an entitlement to care for all veterans, regardless of priority?
- 2) Should those veterans with service-connected disabilities or an inability to pay for care continue to be given priority treatment?
- 3) If funding for the veterans described in Question 2 is secure—that is, if appropriations match or exceed need—what health care services, if any, should be offered to veterans who do not fall within these categories?
- 4) Can the existing system of priority group classification and annual eligibility determinations be made clearer and more predictable?

The PTF considered several criteria as it evaluated these questions, including: recognition and support of VA's historical missions; need to target access for the most at-risk, vulnerable, and highly reliant veteran populations; cost to veterans; adherence to VA's traditional focus on producing rather than purchasing care; and possible effects on VA's triad of patient care, teaching, and research.

The PTF developed recommendations in two separate but inextricably related areas: funding delivery of care within the access standard for Priority Groups 1 through 7 (new) and the need to clarify eligibility and benefits for Priority Group 8.

The PTF developed recommendations in two separate but inextricably related areas: funding delivery of care within the access standard for Priority Groups 1 through 7 (new) and the need to clarify eligibility and benefits for Priority Group 8.

Fully Fund Enrolled Veterans

Recommendation 5.1

The Federal Government should provide full funding to ensure that enrolled veterans in Priority Groups 1 through 7 (new) are provided the current comprehensive benefit in accordance with VA's established access standards. Full funding should occur through modifications to the current budget and appropriations process, by using a mandatory funding mechanism, or by some other changes in the process that achieve the desired goal.

The PTF identified two alternative approaches as illustrations as to how the Executive Branch and Congress might achieve full funding; other strategies might be equally appropriate.

- 1) Form an impartial board of experts, actuaries, and others from outside VA to identify the funding required for veterans' health care that must be included in the discretionary budget request. This part of the budget submission would be protected from the customary budget guidance provided by the Office of Management and Budget. An annual report to Congress describing this requirement, assumptions, and how it was developed would provide insight about, and justification for, funding for veterans' health care needs. The board would review demographic, utilization, and cost trends for the VA population and estimate the funding needed to meet access standards and support VA's traditional missions. Staggered appointments for board members, similar to those of DOD's TRICARE for Life board, would ensure continuity as well as familiarity with the VA system. This board could also review budgeted items involving VA/DOD joint ventures and other initiatives that support collaboration between the two Departments.

- 2) In recent years, legislation has been introduced to require mandatory funding for VA health care as a possible solution. This approach would require that VA be funded in a given year based on a capitated formula established in authorizing language. Funds would continue to be allocated as part of the Department's annual funding process; however the funding requirement would not be subject to the agency budget development process, but based instead on the number of veterans enrolled as of a given date. While this or a similar methodology would not guarantee access, it would most likely eliminate one of the major impediments to providing access: unpredictable or subjectively developed budget requests.

The lack of adequate coding and billing processes has been a significant challenge to collecting money owed to VA; however, the Department currently is focused on improving its first- and third-party collections.

Whatever funding changes occur, VA should continue to aggressively pursue first- and third-party collections under existing statutory authorities. All veterans should be required to provide information on insurance coverage. The lack of adequate coding and billing processes has been a significant challenge to collecting money owed to VA; however, the Department currently is focused on improving its first- and third-party collections.⁸

In addition, VA should continue to work with the Department of Health and Human Services (HHS) to clarify Medicare reimbursement issues for eligible veterans. VA has discussed Medicare reimbursement from the Centers for Medicare and Medicare Services for services provided at VA facilities to treat the non-service-connected conditions of Medicare-eligible veterans. Current law prohibits Medicare from reimbursing VA and DOD for care provided to beneficiaries with Medicare eligibility. However, the Secretary of Veterans Affairs has recently announced an agreement in principle with the Secretary of Health and Human Services for an undertaking that would allow Medicare-eligible veterans to choose VA as their provider under a managed care plan.⁹

⁸ On April 30, 2002, VISN 10 initiated a demonstration to improve billing and collections from third-party insurers. In addition, in October 2002 VA initiated electronic billing for both inpatient and outpatient care and has plans for other system-wide improvements. Preliminary results have been impressive. In fiscal year 2002, VA collected \$1.2 billion, up from \$700 million in fiscal year 2001, representing a 71 percent increase. During the first quarter of fiscal year 2003, the Department is on track to continue this growth in collections.

⁹ Technically, this would occur by VA receiving reimbursement from managed care contractors who will receive payment from Medicare.

Meet Access Standards

VA's health care delivery system is predicated chiefly on providing comprehensive health care services to an enrolled population at VA facilities, but the lack of timely access impedes the accomplishment of this goal. Today, the stated goal for both primary and specialty care appointments within VA is 30 days. VA policy is that veterans with emergency health conditions are seen immediately on a priority basis. If VA is to maintain itself as an integrated health care delivery system, access must be provided to those who are accepted for enrollment. Providing sufficient funding to VA will not by itself guarantee timely access to primary or specialty care appointments. If provided with full funding for Priority Groups 1 through 7 (new), and VA has made responsible enrollment decisions for Priority Group 8 veterans for the year in question, the Department must then hold itself accountable to enrolled veterans by making sure that they are provided appointments within the access standard.

VA's health care delivery system is predicated chiefly on providing comprehensive health care services to an enrolled population at VA facilities, but the lack of timely access impedes the accomplishment of this goal.

Recommendation 5.2

VA facilities should be held accountable to meet the VA's access standards for enrolled Priority Groups 1 through 7 (new). In instances where an appointment cannot be offered within the access standard, VA should be required to arrange for care with a non-VA provider, unless the veteran elects to wait for an available appointment within VA.

Clarify the Status of Priority Group 8

Increasing numbers of Priority Group 8 veterans are relying on VA for all or part of their health care. This heightened reliance is exacerbating the mismatch between the demand for services in VA and available funding. As described earlier, Priority Group 8 veterans are those veterans without compensable service-connected conditions whose incomes are above a geographically-adjusted means test. These veterans have the lowest priority for enrollment and are required to pay for a portion of their care. In addition, for those with private health insurance, VA bills third-party insurers for the cost of some of their care. If eligible Priority Group 8 veterans continue to enroll at the projected rate, they will constitute 27% of enrolled veterans by fiscal year 2012. On January 17, 2003, the

Secretary of Veterans Affairs issued a decision, as required by the Eligibility Reform Act, that precludes additional enrollment of Priority Group 8 veterans because the demand for care by all veterans would have exceeded the available funding. This action confirmed that the current level of resources is not sufficient to allow open enrollment for all veterans.

The present status of Priority Group 8 veterans, a direct result of the Eligibility Reform Act and its implementation by VA, is unacceptable. Individually, veterans do not know from year to year whether they will have access to VA care, and as an organization, VA cannot effectively plan or budget, given the uncertainty. This situation results in less-than-optimal care for veterans with service-connected disabilities and indigent veterans who are unable to get timely care. This uncertainty should be resolved.

Recommendation 5.3

The present uncertain access status and funding of Priority Group 8 veterans is unacceptable. Individual veterans have not known from year to year if they will be granted access to VA care. The President and Congress should work together to solve this problem.^{10,11}

¹⁰ An alternate version of 5.3 was recommended by Member Spanogle and Members Walters and Fleming who have associated with this opinion:

Title 38, USC, defines a veteran as "... a person who served in the active military, naval, or air service, and who was discharged or released therefrom under conditions other than dishonorable."

Eligibility for veterans' health care is defined in the Veterans' Health Care Eligibility Reform Act of 1996 (Public Law 104-262). Veterans eligible and enrolled are placed in one of 8 categories.

The PTF reached consensus on a strong funding recommendation for Priority 1-7 (new), but failed to do so for Priority 8 veterans.

The VA enrolled Priority 8 veterans until January 17, 2003, when the Secretary of the VA suspended new enrollments based on an insufficient budget.

Therefore, we recommend:

- All enrolled Priority 8 veterans would be required to identify their public/private health insurer(s).
- VA would be authorized as a Medicare provider for Priority 8 veterans and be permitted to bill, collect and retain all or some defined portion of third party reimbursements from CMS for the treatment of non-service connected medical conditions.
- VA should be authorized to offer a premium-based health insurance policy to any enrolled Priority 8 veteran with no public/private health insurance.
- All enrolled Priority 8 veterans would be required to make co-payments for treatment of non-service connected medical conditions and prescriptions.
- All enrolled Priority 8 veterans with no public/private health insurance would agree to make co-payments and pay reasonable charges for treatment of non-service connected medical conditions.

Why not a "pay as you go system" for Priority 8's? Medicare subvention for VA is under active consideration by the VA and HHS. VA is seeking authority to require "proof of insurance." VA, like other federal agencies, could offer a health insurance plan. VA has had collection authority since 1986.

¹¹ Members Alvarez and Wallace support an expanded version of Recommendation 5.3 that will guarantee access and funding for Priority Group 8 veterans.

Conclusion

The apparent mismatch in VA between demand for access and available funding is too large to be solved by collaboration alone. Collaboration and sharing between VA and DOD are not likely to compensate for significant core under-funding in either Department. Moreover, the PTF is concerned that the mismatch between funding for the VA health care system and the demand for services from enrolled veterans affects the delivery of timely health care and impedes efforts to improve collaboration between VA and DOD.

Congress and the Executive Branch must work together to provide VA with full funding to meet demand, within access standards, for Priority Groups 1 through 7 (new). The PTF also recommends that VA be accountable for meeting its established access standards for Priority Groups 1 through 7; when appointments cannot be offered within the standard, the Department should be required to offer the enrolled veteran an appointment with a non-VA provider.

Finally, the current situation with regard to Priority Group 8 is unacceptable. The PTF recommends that the President and Congress work together to resolve the status of this group of veterans.

The PTF recommends that VA continue to improve collection of all revenues that are appropriate (e.g., first- and third-party collections) and should continue to work with HHS to further clarify Medicare reimbursement issues for eligible veterans.

A P P E N D I X A

Executive Order 13214

APPENDIX A

Executive Order 13214 of May 28, 2001

President's Task Force to Improve Health Care Delivery for Our Nation's Veterans

By the authority vested in me as President by the Constitution and the laws of the United States of America, including the Federal Advisory Committee Act, as amended (5 U.S.C. App.), and in order to provide prompt and efficient access to consistently high-quality health care for veterans who have served the Nation, it is hereby ordered as follows:

Section 1. *Establishment.* There is established the President's Task Force to Improve Health Care Delivery for Our Nation's Veterans (Task Force).

Section 2. *Membership.* The Task Force shall be comprised of 15 members appointed by the President. Two of the 15 members shall serve as co-chairs of the Task Force. The Task Force membership shall include health care experts, officials familiar with Department of Veterans Affairs and Department of Defense health care systems, and representatives from veteran and military service organizations.

Section 3. *Mission.* The mission of the Task Force shall be to:

(a) identify ways to improve benefits and services for Department of Veterans Affairs beneficiaries and Department of Defense military retirees who are also eligible for benefits from the Department of Veterans Affairs through better coordination of the activities of the two departments;

(b) review barriers and challenges that impede Department of Veterans Affairs and Department of Defense coordination, including budgeting processes, timely billing, cost accounting, information technology, and reimbursement. Identify opportunities to improve such business practices to ensure high-quality and cost-effective health care; and

(c) identify opportunities for improved resource utilization through partnership between the Department of Veterans Affairs and the Department of Defense to maximize the use of resources and infrastructure, including: buildings, information technology and data sharing systems, procurement of supplies, equipment and services, and delivery of care.

Section 4. Administration.

(a) The Department of Veterans Affairs shall, to the extent permitted by law, provide administrative support and funding for the Task Force.

(b) Members of the Task Force shall serve without any compensation for their work on the Task Force. Members appointed from among private citizens of the United States, however, while engaged in the work of the Task Force, may be allowed travel expenses, including per diem in lieu of subsistence, as authorized by law for persons serving intermittently in Government service (5 U.S.C. 5701-5707), to the extent funds are available.

(c) The co-chairs of the Task Force shall appoint an Executive Director to coordinate administration of the Task Force. To the extent permitted by law, office space, analytical support, and additional staff support for the Commission shall be provided by executive branch departments and agencies as directed by the President.

(d) The heads of the executive branch departments and agencies shall, to the extent permitted by law, provide the Task Force with information as requested by the co-chairs.

(e) At the call of the co-chairs, the Task Force shall meet as necessary to accomplish its mission.

(f) The functions of the President under the Federal Advisory Committee Act, as amended, except for those in section 6 of that Act, that are applicable to the Task Force, shall be performed by the Department of Veterans Affairs, in accordance with the guidelines that have been issued by the Administrator General Services.

Section 5. Reports. The Task Force shall report its findings and recommendations to the President, through the Secretary of Veterans Affairs and Secretary of Defense. The Task Force shall issue an interim report in 9 months from the date of the first meeting of the Task Force. The Task Force shall issue a final report prior to the end of the second year of operation.

Section 6. Termination. The Task Force shall terminate 30 days after submitting its final report, but no later than 2 years from the date of this order.

THE WHITE HOUSE,
May 28, 2001

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A P P E N D I X B

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A P P E N D I X C

Abbreviations

APPENDIX C

Abbreviations

BCF	Basic Core Formulary
BRAC	Base Realignment and Closure
CARES	Capital Asset Realignment for Enhanced Services
CHCS	Composite Health Care System
C&P	Compensation and Pension
CPG	Clinical Practice Guidelines
DFAS	Defense Finance and Accounting Service
DIMHRS	Defense Integrated Military Human Resources System
DOD	Department of Defense
DOEHRS	Defense Occupational and Environmental Health Readiness System
EMR	Electronic Medical Record
FHIE	Federal Health Information Exchange
FSS	Federal Supply Schedule
GAO	General Accounting Office
HHS	Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act
IM/IT	Information Management/Information Technology
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
MAP	Medical Advisory Panel
MHS	Military Health System
MTF	Military Treatment Facility
NDAA	National Defense Authorization Act
OMB	Office of Management and Budget
P&T	Pharmacy and Therapeutics
PDTS	Pharmacy Data Transaction Service
PEC	Pharmacoeconomic Center

President's Task Force To Improve Health Care Delivery For Our Nation's Veterans

PBM	Pharmacy Benefits Management
PTF	President's Task Force to Improve Health Care Delivery for Our Nation's Veterans
PRV	Plant Replacement Value
RAP	Recruit Assessment Program
TMOP	TRICARE Mail Order Pharmacy
VA	Department of Veterans Affairs
VAMC	VA Medical Center
VANF	VA's National Formulary
VBA	Veterans Benefit Administration
VERA	Veterans Equitable Resource Allocation
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

A P P E N D I X D

**Technical Discussion of
Information Management/
Information Technology Issues**

APPENDIX D

Technical Discussion of Information Management/ Information Technology Issues

This part of the appendix was developed to:

- Describe the process approach used in IM/IT deliberations over the lifetime of the PTF, and its application to developed findings and recommendations;
- Reduce technical IM/IT discussion of various areas described in Chapter 3, and
- Address IM/IT findings of the PTF's research from a more technical perspective.

PTF Approach

Information management and technology (IM/IT) can support many of the processes needed to achieve a seamless transition from service member to veteran status and to support VA/DOD collaboration across a spectrum of comparable requirements.

For example:

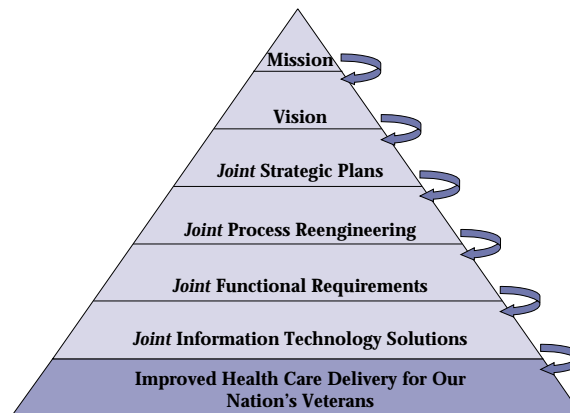
- An interoperable, bi-directional electronic medical record (EMR), covering the full lifecycle of a service member that would facilitate delivery of health care services to veterans in a manner that enhances effectiveness of care, reduce medical errors and attendant costs, and support epidemiological studies;
- Data standardization, with reference terminology and information models, critical to achieving information interoperability; and
- VA access to the appropriate personnel location, occupational exposure, and injuries information to assist in VA benefits determinations and epidemiological research.

However, there is often a temptation to throw technology at a challenge and wait for collaboration to happen as a result. IM/IT is not a solution that can be developed outside the context of each Department's organization, mission, and strategic planning. IM/IT solutions require active involvement of leadership to be effective.

The PTF's preferred top-down VA/DOD joint planning and execution model is shown in Figure A-1, illustrating the relationships between mission, actions, and outcomes in the IM/IT development process. Once a joint plan is established, managers at all levels must use it to guide re-engineering processes to improve services to beneficiaries or achieve operating efficiencies. Re-engineering may require modified policies, which then drive functional IM/IT requirements and form the basis for acquiring, developing, or enhancing systems that support the re-engineering process across both Departments.

Investment in IM/IT alone will rarely produce improvements. The leaders of both Departments must set priorities and identify desired improvements, which should be expressed in terms of improved outcomes, dollars, or other measures that reflect the return on investment.

Figure A-1 Process Model for Developing Joint IM/IT Solutions



Effective interoperable or joint IM/IT solutions that significantly improve VA/DOD collaboration depend on senior executive commitment to and involvement in planning, synchronization between the Departments, and motivation at all levels with accountability for results.

At the most basic level, joint VA/DOD purchasing of IM/IT commodities provides an opportunity to reduce costs through combined buying power. For this to be successful, joint processes must be defined and managed.

Keys to Success in Sharing Information

National Standards

Lack of standardization in the terms used within medical records and the methods used to transmit or communicate electronically stored health information impede VA/DOD sharing of medical information. Adopting compatible information architectures and common standards could improve the transition to veteran status by enabling the determination of veterans' benefits, and enhancing health care delivery as a result of interdepartmental sharing of information. The types of common standards needed and examples are provided in Table A-1.

Table A-1: Examples of Standards to Support VA/DOD Health Information Exchange

Type of Required Common Standard	Example Standard
Messaging and Communication	Health Level 7 (HL7)
Security and Authentication	Triple Data Encryption Standard (Triple DES) Public Key Infrastructure (PKI)
Privacy and Data Protection	TBD
Coding and Classification	International Classification of Diseases (ICD)-10
Controlled Medical Vocabulary	Systematized Nomenclature of Medicine (SNOMED) Logical Observation Identifiers Names and Codes (LOINC)

The Need for a Controlled Medical Vocabulary

To understand the importance of using consistent communication protocols, consider the following example. Using the HL7 messaging standard, three sites might report the result of blood typing as follows:

Site 1: OBX | 1 | CE | **ABO**^ABO GROUP || **O**^Type O |

Site 2: OBX | 1 | CE | **BLDTYP**^ABO GROUP || **TYPEO**^Type O |

Site 3: OBX | 1 | CE | **ABOTYPE**^ABO GROUP || **OPOS**^Type O |

The message would be sent and received accurately and a physician viewing each of these messages would interpret them as similar—the individual has Type O blood. However, a computer would not automatically recognize these results as being similar.¹ Thus, the data would be “machine-readable,” but not “computable.” In simplistic terms, with this form of data transmission, the computer functions as little more than an expensive fax machine with a storage capability added.

However, if each site also used the Logical Observation Identifiers Names and Codes (LOINC) for laboratory results standard, the messages would be identical in every respect.

As a result, both a physician and a computer could accurately interpret the results as the same. Data standardization, as shown in this example, is important in achieving interoperable electronic medical records (EMRs) to support health care delivery and the conduct of epidemiological studies.

It should be noted that even when different entities adopt common standards, interoperability does not necessarily ensue, because some standards allow variances for use. For example, the HL7 standards identify a specific format for composing a message, but allow flexibility in the type of data permitted and how it is structured. Without using the same implementation guidelines, two organizations using the same HL7 standard could transmit and receive a message, but not be able to read what is in the message. Since having a high percentage of the same or compatible standards does not necessarily guarantee interoperability, VA and DOD should consider the development and use of implementation guides, such as those provided for the HIPAA X12N community, to ensure interoperability.

Reference Terminology

Beyond standardized terminology, establishing semantic relationships among elements in the terminology scheme—i.e., “reference terminology” for specific groups of terms—could be used for a variety of purposes to the benefit of the Departments and their beneficiaries. For example, clinical practice guidelines for diabetes management require an annual check of glycosylated hemoglobin (or HbA1c level), which can be assessed through several laboratory tests. A reference terminology model would facilitate automatic recognition that a specific clinical practice guideline has been met by storing all of the laboratory tests that fulfill guideline criteria. Appropriate reference terminology models could also prove helpful in billing. For example, a reference terminology model that interrelates Common Procedural Terminology (CPT) codes with Healthcare Common Procedure Codes (HCPCS) could assist in properly completing the UB92 form that is necessary for Medicare billing.

¹ Presentation by Stan Huff to the National Committee on Vital and Health Statistics. May 17, 1999, <http://ncvhs.hhs.gov/990517p6.ppt>.

To achieve maximum benefit from standardized terminology and reference terminology models, appropriate database structures must be used. An appropriate reference information model within the database will provide the data file structure needed to store the reference terminology model information in a useable manner.

VA/DOD Health Care Initiatives

Technical Standards

In fiscal year 2002, VA and DOD jointly completed an analysis of the technical standards used by both Departments' health care systems, specifically for 76 functional areas in the VA and for comparable functions in DOD. The analysis revealed that DOD standards were compatible or did not require compatibility for 96 percent (73 of 76) of VA functional areas (note: telecommunications was not a part of this analysis). Areas not requiring compatibility were those with functions or services internal only to VA.²

Consolidated Health Informatics

VA, DOD, and Health and Human Services (HHS) participate in the Consolidated Health Informatics (CHI) Initiative, with HHS leading the effort. The goal of the CHI initiative is to establish federal health information interoperability standards as the basis for electronic health data transfer in all activities and projects and among all agencies and departments.³ CHI also plans to encourage adoption of the same or similar standards by other public and private sector entities. As part of this initiative, VA and DOD have agreed to adopt:

- Logical Observation Identifiers Names and Codes (LOINC) for laboratory test results⁴
- HL7 versions 2.4 and above, XML encoded for data transfer
- X12N transaction set as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA)
- Digital Imaging and Communications in Medicine (DICOM) for digital imaging
- ISO 1073 standard for internal use for connecting medical devices to computers

² DOD response to the PTF (IMIT Workgroup) Data Call, Item 4.a.1, "Military Health System and Veterans Health Administration Information Sharing- Analysis of Technical Standards," received March 11, 2002.

³ Reported at the National Committee on Vital and Health Statistics, August 29, 2002 meeting.

⁴ LOINC is a voluntary effort housed in the Regenstrief Institute for Health Care. LOINC codes allow users to merge clinical results from many sources into one database for patient care, clinical research, or management. The LOINC database currently contains about 20,000 observational terms related to laboratory testing. For more information, go to www.loinc.org.

Enterprise Architecture

Additional VA/DOD efforts include mapping of Department enterprise architectures to each other, a laboratory data sharing and interoperability initiative, collaborative efforts in role-based security standards, and collaborative drug name mapping. A VA representative sits on the DOD Data Standards Configuration Management Board, which aims to ensure enterprise data consistency and effective exchange within the military health system (MHS) as well as with external sources. Overarching goals are to reduce management costs, improve data quality, and manage change related to enterprise data.

Additional Initiatives

Agreements on additional standards are expected in the near future. For example, VA and DOD are addressing EMR interoperability through data standardization between the Clinical Data Repository used by DOD's Composite Health Care System II and the Health Data Repository being developed for VA's HealtheVet-VistA system. Once achieved in FY 2006, this will represent a significant step in obtaining interoperability.

National Efforts in Standards Development

It is important to view VA/DOD efforts in the context of the national trend toward standards development. Since the 1980s, a number of organizations have been actively pursuing some subset of standards, including:

- *American Medical Association* — Current Procedural Terminology (CPT) codes
- *American Nurses Association* — North American Nursing Diagnosis Association (NANDA) standards; Nursing Interventions Classification (NIC), Nursing Outcomes Classifications (NOC)
- *Accredited Standards Committee* — X 12N (provider-payer transaction standards)
- *American Standards for Testing and Materials* — E31 (Healthcare Information Standards)
- *College of American Pathologists* — Systematized Nomenclature of Medicine (SNOMED) clinical terminology
- *Digital Imaging and Communications in Medicine (DICOM)* — radiological imaging standards and codes
- *Health Level 7* — administrative/clinical message format standards

- *Institute of Electrical and Electronic Engineers* — 1073 (medical device transaction standards)
- *Logical Observation Identifiers Names and Codes (LOINC)* — code sets laboratory results, clinical observations, and diagnostic study observations
- *National Council of Prescription Drug Programs* — retail pharmacy transaction standards

As VA and DOD collaborate on standards adoption and implementation, they should expand their involvement with the standards development organizations. For example, VA, DOD, and HHS leadership have been negotiating with the College of American Pathologists for a government-wide license agreement for the use of the Systematized Nomenclature of Medicine (SNOMED) clinical terminology. Although this would not be a “complete” clinical terminology solution, it would be a tremendous step in the right direction for the Departments and for all government entities involved in health care. Once achieved, the Departments could prioritize the next set of terminology for standardization and work through the standards development organizations to move forward.

Failure to become more actively involved with standards development organizations could result in expenditure of time and energy only to find that the outcomes are incompatible with those of particular standards development organizations. For example, VA and DOD are working together on drug name mapping. It is important that this work be discussed with the HL7 vocabulary committee to get their support. Furthermore, VA/DOD efforts to establish reference terminology and information models could move federal agencies and the private sector to closer agreement on useful standards, as well as lay the foundation for broad-based expansion of the medical IM/IT market in the commercial sector. VA and DOD should establish shared reference information terminology and information models—for example EMR, VA/DOD clinical practice guidelines, occupational exposures, and the electronic DD 214—for consideration by standard development organizations, which could accelerate the national processes in a way that best addresses VA and DOD needs.

Moreover, the combined purchasing power of VA and DOD provides a unique opportunity to further influence the adoption of standards through the acquisition process. As standards are adopted, acquisitions should begin requiring that vendors use those standards in the products being offered. For example, if laboratory equipment is being acquired, vendors could be required to use fully specified LOINC terms.

In addition to the need to adopt and implement common standards, it will be necessary for VA and DOD to continue to be responsive to change as it occurs. For example, in November 2002, three health care associations⁵ wrote to HHS and the National Committee on Vital and Health Statistics calling for adoption of new standards to replace the ICD-9-CM coding classification required by HIPAA, specifically use of the new ICD-10-CM diagnosis codes and ICD-10-PCS procedure codes for all hospital inpatient services.⁶

Another example is DOD's use of the National Council of Prescription Drug Programs' codes, which has enabled DOD to provide an automated tool to review a beneficiary's new prescription against all previous prescriptions filled though any point of service in the MHS, including MTFs, retail network pharmacies, and DOD's National Mail Order Pharmacy program. This has improved the quality of prescription services and enhanced patient safety by reducing the likelihood of adverse drug-to-drug interactions and duplicate treatments. It has also resulted in higher quality medical care based on proper medication control, reduction of fraud and abuse, and better management reporting and control. However, the National Council of Prescription Drug Programs' codes do not contain all of the information that clinical providers may need, such as form and dosage. As existing standards are modified to include this information or new standards are developed, the Departments should collaborate on what standard should be adopted and implemented to better support VA/DOD collaboration while maintaining the ability to review prescription information from retail network pharmacies.

A number of private sector groups also focus on health information standards. In June 2002, the Markle Foundation launched an initiative designed to bring together government, industry, healthcare leaders, and consumer advocates to establish consensus on a core set of health care data standards that have the potential to improve clinical decision-making, reduce medical errors, accelerate research on patient outcomes, and increase the effectiveness of public health efforts.⁷ VA and DOD are both participants in this initiative.

Another opportunity for expanded VA/DOD engagement is the Health Legacy Partnership, a government-private partnership of The Joseph H. Kanter Family Foundation and the Agency for Healthcare Research and Quality. The goal of the partnership is to create a comprehensive database of health outcomes information for a wide range of diseases that will be easily accessible to patients and doctors. Specifically, the partnership aims to:

- Improve healthcare decision making by giving people information—including print and Internet resources—based on scientific research;

⁵ American Hospital Association, Federation of American Hospitals, and the Advanced Medical Technology Association.

⁶ Health Data Management website, "Letter to HHS: We Need ICD-10," www.healthdatamanagement.com/html/news/NewsStory.cfm?DID=9367.

⁷ Markle Foundation Press Release, "Markle Foundation Launches Initiative to Promote Adoption of Key Clinical Health Information Standards," June 21, 2002, www.markle.org/news/_news_pressrelease_062102.stm.

- Support the development of a national outcomes database that will be used by doctors and patients to determine which treatments work best for specific diseases and conditions; and
- Encourage the standardization of health outcomes data throughout the healthcare system so that a national outcomes database can be developed and used.⁸
- In addition, the Institute of Medicine (IOM) has formed a Committee on Patient Safety Data Standards “to produce a detailed plan to facilitate the development of data standards applicable to the collection, coding and classification of patient safety information. The plan will apply to both adverse event data and errors data.”⁹ IOM is concentrating on an area where there is not a set of existing standards that offer an “eighty percent solution”; thus it provides an example of one the many areas where limited data standards are available for adoption and/or refinement.

In High Priority Areas, DOD and VA Should Not Wait for National Standards

The absence of standards does not mean that VA/DOD IM/IT and data sharing cannot take place. Progress in the absence of standards adds an additional layer of complexity to the task of sharing meaningful data and may not succeed completely, but the lack of standards should not be used as an excuse to avoid sharing. If VA/DOD sharing were to wait until all IM/IT standards were in place, significant opportunities for collaboration would be missed to the detriment of the beneficiaries of the two systems.

In high-priority areas, the Departments should mutually develop and adopt enterprise reference terminology. This agreed upon terminology could become the basis on which to build a nationwide consensus through the appropriate standards development organization. One high priority is reference terminology and information models needed to implement and use the joint VA/DOD clinical practice guidelines, document occupational exposures and occupational specialties, or provide specific military service record information.

Developing standards and enterprise reference terminologies is a time-consuming process, requiring a significant amount of data sharing. When non-standardized data are shared, a method of “mapping” the data is often used to achieve more meaningful data exchange between information systems. In mapping, each variation of how a term or data element is used is linked to a single term. For a health record, there are tens of thousands

⁸ www.healthlegacy.org.

⁹ Institute of Medicine website, [http://www.iom.edu/IOM/IOMHome.nsf/Pages/Patient+ Safety+ Data+ Standards](http://www.iom.edu/IOM/IOMHome.nsf/Pages/Patient+Safety+Data+Standards).

of terms that must be mapped and validated. In laboratory results alone, there are thousands of terms. Accurate terminology mapping is difficult to accomplish and maintain over time. However, mapping can be an effective solution to sharing while data standards are being developed, adopted, and implemented in a compatible manner. Careful consideration needs to be given to the level of effort and skill mix of VA and DOD personnel involved in mapping efforts. Busy health care providers with little or no training in nosology are probably not the optimal resources to use in an ad hoc manner for this important but detailed work.

Other Areas Impacting Interoperability

Security and Privacy Issues

In addition to security and privacy requirements included in HIPAA, there is an extensive body of law and regulation relevant to the information content of the EMR. For example, DOD systems must maintain accreditation in accordance with the Defense Information Technology System Certification and Accreditation Program and VA systems must maintain accreditation with the VA Information Technology System Certification and Accreditation Program. Data use agreements between the Departments govern the release, use, and any further sharing of information by the receiving Department for data originating from the other Department.

HIPAA also addresses intradepartmental information security practices, limiting access to protected patient information by staff engaged in actual treatment of the patient or when necessary to do their jobs, such as billing. In testimony to Congress in September 2002, VA leadership has recognized, as an on-going material weakness, the lack of adequate information security measures to protect sensitive data from internal attack or inappropriate disclosure to unauthorized personnel within VA. This is an area that will need concentrated attention.

Comprehensive Service Member Data

When fully implemented, the Defense Integrated Military Human Resources System (DIMHRS) consolidated personnel and pay system will replace each Service's individual legacy personnel system. The successful implementation of DIMHRS will be a significant step forward in providing a single record of service and service-related activities. This will help separating military personnel provide whatever documentation is necessary to receive timely access to benefits. According to the schedule, implementation is to begin in 2004 and be completed in 2006. However, many elements related to tracking an individual's specific location, activities, and exposures will remain undocumented.

The Defense Occupational and Environmental Health Readiness System (DOEHRS) is designed to support the Hearing Conservation (HC), Industrial Hygiene (IH), and Occupational Medicine (OM) programs within the MHS. To date, only the Hearing Conservation module has been designed, tested, and fielded. DOEHRS-HC has become the standard tool for hearing conservationists and the occupational medicine community. DOEHRS-HC capabilities include noise exposure surveillance, hearing loss referrals, auditory readiness documentation, and medical outcomes documentation. When DOEHRS-HC is integrated with CHCS II, it will be possible to access near real-time audiometric data that were entered at another location. The central repository for audiometric data will allow authorized personnel to query the database for threshold shift information, Occupational Safety and Health Administration (OSHA) reportable hearing loss, and compensation/disability costs associated with hearing impairment. The data can be sorted and accessed by person, service duty occupation code, pay grade, age, and other similar categories.

The requirements for the Industrial Hygiene and Occupational Medicine modules have been completed and validated. The Industrial Hygiene portion is funded and development began in early 2003. It will provide data on exposure surveillance in workspaces and in the field in accordance with OSHA and other regulatory and Service guidance. The Occupational Medicine portion is incorporated into the clinical documentation portion of the CHCS II program. Completion of the Industrial Hygiene module and implementation of the Occupational Medicine portions of CHCS II will be central to creating a robust system.

These initiatives have the potential to enhance DOD's ability to collect relevant information on service members and their potential exposure to hazards during their service, but DOD must adopt specific policies on sharing such information with VA to support the continuity of health care of veterans. The Departments will need to collaborate to determine what data will be released and the timeframe for release.

Barriers to Interoperability

Clinical Data

Achieving interoperability of DOD's Clinical Data Repository and the VA's Health Data Repository is complex. The DOD Clinical Data Repository is based on the 3M Health Data Dictionary and MEDCIN, concept-based ontologies¹⁰ used in CHCS II for solving: 1) how data is retrieved from disparate source systems with different data schemas and how it

¹⁰ Ontology is a description (like a formal specification of a program) of the concepts and relationships that can exist for an agent or a community of agents.

is represented and stored in a standard meaningful way in the Clinical Data Repository; and 2) how granular clinical data is captured at the point of care from clinical practitioners and stored in the Clinical Data Repository. A multi-stepped integration process was used to map between MEDCIN, the Health Data Dictionary, and other controlled medical vocabularies and classifications schemes, such as ICD codes.¹¹ Given the mapping approach being used by DOD for its Clinical Data Repository, to achieve standardization and interoperability, VA's Health Data Repository would have to use the same products and map between them in the same way. On the other hand, establishing and implementing reference terminology and information models to achieve information interoperability would obviate the needs for "de facto" standardization through use of identical commercial solutions.

Size of the Organizations

Interoperability is also hindered by the size of the two health care systems. In November 2002, DOD's Information Technology Acquisition Board approved a limited deployment of CHCS II following a successful pilot project in four DOD hospitals. Full deployment of CHCS II and VA's HealtheVet-VistA system are prerequisites to achieving the desired clinical data interoperability.¹² An independent review of CHCS II conducted in 2002 estimated that the system will process 149,000 outpatient encounters per day; 31 million visits per year; and have 4,200 active, concurrent users on peak days.¹³

A Case Study of VA/DOD Collaboration

While this discussion of IM/IT collaboration suggests the need for a structured model to ensure efficiency in systems integration, it continues to be possible for the Departments, in the midst of successful collaboration, to "agree not to agree." During the PTF's review of collaborative activity between the two Departments, a case study was developed to describe a perfect opportunity for development of a shared common enterprise wide scheduling system. The case study, now held in PTF archives, describes how a "model of collaboration" resulted in a common decision to individually acquire/develop separate systems.

Case Study Overview

Over the course of several months, VA and DOD collaborated on their plans for enterprise wide scheduling systems. From June 2001 to October 2001, DOD participated in the VA Scheduling Replacement Business Process Reengineering workshops. Within DOD, concept

¹¹ DOD Nov 25, 2002 e-mail response to IM/IT workgroup data call.

¹² *Federal Computer Week*, "DOD approves electronic medical record system," November 11, 2002, page 9.

¹³ Gartner, Inc.

exploration for a DOD Enterprise Wide Scheduling system began in September of 2001. An Integrated Product Team was chartered with shared membership.^{14,15}

Project status reports were shared between the agencies, as well as email discussions on related topics. Invitations to key meetings from both agencies were provided so project progress and discussions might continue. The VHA Project Manager attended the DOD kickoff conference in March 2002, which included discussions of methodology, tasks, timelines, summary of accomplishments to date, project structure, and a synopsis of the VA COTS Trade Study. DOD was provided copies of all the VA Current and Future Model documents, Project Trade Study results, system Specification Requirements, and highlights regarding features and functionality.

- The ongoing collaboration between VA and DOD resulted in improved systems requirements. VA and DOD both developed and revised requirements inspired by the other agency. In addition, the DOD market survey applied lessons learned from the trade study VA completed. This resulted in an enhanced process, improved schedule, and reduced cost for the DOD market survey.
- Although the overall DOD Enterprise Wide Scheduling initiative was broader than the VA's Outpatient Scheduling initiative, the Departments determined an overlap of requirements greater than 80 percent.
- Given a greater than 80 percent overlap in requirements, a logical outcome would be for VA and DOD to embrace a joint scheduling system. However, that is not the decision made by the Departments.

The IM/IT System Decision

DOD's Management Initiative Decision No. 905 addresses the use of COTS software:

- "Expanded use of COTS software should streamline business processes, increase operational efficiency, and yield significant savings."
- It directs the DOD CIO "to develop an action plan to vigorously promote policies and establish incentives designed to increase the use of COTS across DOD."

For DOD, a COTS solution allowed application of Federal and DOD COTS policies and offered many efficiencies including: reduced cost by 50 percent; increased speed of delivery while providing tested state of the market technology; allowed movement from legacy system by FY07; and a return on investment of 1:6.

¹⁴ DOD Response to PTF Data Call, "PTF Data Call for DOD and VA Scheduling Solutions," received August 13, 2002.

¹⁵ VA Response to PTF Data Call, "Enterprise Scheduling: VHA/DOD Collaborative Efforts," received August 13, 2002.

On the other hand, VA made the decision to build an outpatient scheduling system on the current VistA scheduling system rather than purchase a COTS product. VA analysis indicated that building a new system would: be less costly than acquiring a COTS product; give VA ownership and control over the code, making them vendor independent; allow VA to share the system with other public agencies such as the Indian Health Service, State and local public health entities, and partners/affiliates at a low or no cost to the recipient; and provide a return on investment of 1:2.4. It is unclear:

- To what extent DOD explored the options available for COTS scheduling suites that could be “decoupled” and provide the outpatient scheduling module as a stand-alone product to facilitate VA collaboration on outpatient scheduling. The cost impact of a requirement for “decoupling” the outpatient scheduling module is unknown.
- Whether VA considered options such as a broadly negotiated software license fee as an alternative that would allow broad sharing of an out-patient scheduling application without needing to build and own the source code.
- To what extent VA explored the feasibility and cost of a decoupled outpatient scheduling module in the COTS cost analysis.
- Whether the return on investment analysis done by VA included an offset for the technical and schedule risks introduced by building a system rather than purchasing a COTS product.

The Leadership Decision

This joint decision at the IT level—for DOD to buy a COTS product and VA to build its own system—was briefed to the VA/DOD Health Executive Council (HEC) on December 18, 2002 and subsequently to the VA/DOD Joint Executive Council (JEC) on January 23, 2003.

DOD and VA reported that the recommendations approved by the HEC, and left unchanged by the JEC, were:

- Continue close collaboration;
- In DOD acquisition of COTS suite (outpatient scheduling, inpatient scheduling, operating room scheduling, registration, and admissions, discharges, and transfers), assure access to solution for VA and other agencies;

- In VA build of outpatient scheduling, assure technical, design and messaging compatibility with DOD COTS suite;
- VA and DOD ensure interoperability for outpatient scheduling;
- VA proceed with build/own; and
- DOD proceed with competitive acquisition of COTS solution with option in contract for broader federal acquisition.¹⁶

Conclusion

In spite of a model process embraced by each Department and collaborative efforts to develop requirements that result in an overwhelming overlap of these requirements, differing Departmental philosophies, organizational policies, and practices will continue to undermine efficient and economic interoperable IM/IT system development. These same policies and preferences will likely exist when future systems of mutual interest, with the potential to support VA/DOD collaboration, come under consideration. The Departments will face challenges in taking advantage of potential opportunities for avoidance of cost, technical risk reduction, and integration of system interoperability. The approach of separate but interoperable systems significantly increases the risk of continued inefficiencies and frustration in VA/DOD collaboration efforts. But it also reinforces the importance of examining these differences to ascertain the relevance and value to the accomplishment of the mission of each department. As this appendix illustrates, without resolution of the noted differences and involvement of committed Department leadership, significant problems will continue to create loss of potential efficiency in future efforts to ensure VA/DOD collaboration.

¹⁶ Joint VA/DOD briefing given to the PTF Staff on January 7, 2003.

APPENDIX E

PTF Site Visits

APPENDIX E

PTF Site Visits

VA/DOD Joint Venture Locations

Location	VA Site	DOD Site	Date
Albuquerque, NM	New Mexico VA Health Care System	377th Air Force Medical Group, Kirtland Air Force Base	Jan. 22-25 and June 27, 2002
Anchorage, AK	Alaska VA Healthcare System and Regional Office	3rd Medical Group Elmendorf Air Force Base	Oct 21-26, 2001 and March 3-9, 2002
El Paso, TX	El Paso VA Health Care System	William Beaumont Army Medical Center	June 26, 2002
Honolulu, HI (Briefing in Rosslyn, VA)	VA Medical And Regional Office Center Honolulu Mr. Dave Burge	Tripler Army Medical Center Honolulu MG Nancy Adams	March 19, 2002
Key West, FL	VA Outpatient Clinic of VAMC Miami	Navy Branch Clinic of Jacksonville Naval Hospital	Dec. 27-28, 2001
Las Vegas, NV	VA Southern Nevada Healthcare System, Mike O'Callaghan Federal Hospital	99th Medical Group, Nellis Air Force Base Mike O'Callaghan Federal Hospital	Jan. 22-25 and June 28, 2002
Northern California	VA Northern California Health System (Fairfield Clinic, Sacramento VAMC, San Francisco VAMC)	60th Medical Group David Grant Medical Center, Travis Air Force Base, Fairfield	Sept.18-20, 2002

VA and DOD Locations

Location	VA Facility	DOD Facility	Date
Chicago, IL	VA National Acquisition Center (Hines)	N/A	April 1-3, 2002
Fairbanks, AK	Alaska VA Health Care System and Regional Office CBOC	Bassett Army Community Hospital	October 24, 2001 and March 6, 2002
Fayetteville, NC	Fayetteville VAMC	Womack Army Medical Center, Ft. Bragg	July 18-19, 2002
Ft. Eustis, VA	N/A	McDonald Army Community Hospital	October 20-21, 2002
Jacksonville, NC	VA Pre-Discharge Office, Camp LeJeune	Naval Hospital, Camp LeJeune	July 20, 2002
Louisville, KY	VAMC Louisville	Ireland Army Community Hospital, Ft. Knox	Aug. 13-14 and Sept. 19, 2002
Menlo Park, NJ	NJ Veterans Memorial Home	NJ Department of Military and Veterans Affairs	Sept. 4, 2002
New York	VA New York Harbor Healthcare System (Brooklyn and New York City)	U.S. Army Garrison, Ainsworth Health Clinic, Ft. Hamilton, NY	April 18-19, 2002
North Chicago, IL	North Chicago VAMC	Great Lakes Naval Hospital	April 25, 2002
Palo Alto, CA	VA Palo Alto Health Care System	N/A	Sept. 19, 2002
Philadelphia, PA	N/A	Defense Supply Center	Feb. 23, 2002
Portsmouth, VA	Hampton VAMC	Portsmouth Naval Hospital	July 17, 2002
San Antonio, TX	N/A	Ft. Sam Houston and DOD Pharmacoeconomic Center	March 25-27, 2002
Seattle, WA	Puget Sound VA Health Care System	Madigan Army Medical Center, Bremerton Naval Hospital	July 24-25, 2002
Tacoma, WA	Spokane VAMC	Fairchild Air Force Hospital	July 28, 2002
Washington, DC	National Naval Medical Center, Bethesda	Washington DC VA Medical Center	Feb. 15, 2002
West Palm Beach, FL	West Palm Beach VA Medical Center	N/A	April 17-19, 2002

A P P E N D I X F

VA Health Care Enrollment Priority Groups and Copayment Requirements

APPENDIX F

VA Health Care Enrollment Priority Groups and Copayment Requirements (as of January 2003)

To be eligible for enrollment for VA health care benefits, a veteran—defined in section (101)(2) of title 38, U.S. Code, as a person who served in the active military, naval, or air service, and who was discharged or released under conditions other than dishonorable—must have served a minimum of two years if discharged after September 7, 1980, or, if called up under Presidential order, must complete the term of the order. For example, Reservists called to duty for Operation Desert Storm who completed the terms of their order, even if only a few months, are veterans and, therefore, eligible for VA health care. In DOD, active duty personnel, their family members, retirees and their family members are entitled to receive health benefits.

Priority Group 1

- Veterans with service-connected disabilities rated 50% or more disabling

Priority Group 2

- Veterans with service-connected disabilities rated 30% or 40% disabling

Priority Group 3

- Veterans who are former POWs
- Veterans awarded the Purple Heart
- Veterans whose discharge was for a disability that was incurred or aggravated in the line of duty
- Veterans with service-connected disabilities rated 10% or 20% disabling
- Veterans awarded special eligibility classification under Title 38, U.S.C., Section 1151, "benefits for individuals disabled by treatment or vocational rehabilitation"

Priority Group 4

- Veterans who are receiving aid and attendance or housebound benefits
- Veterans who have been determined by VA to be catastrophically disabled

Priority Group 5

- Non-service-connected veterans and non-compensable service-connected veterans rated 0% disabled whose annual income and net worth are below the established VA means test thresholds
- Veterans receiving VA pension benefits
- Veterans eligible for Medicaid benefits

Priority Group 6

- World War I veterans
- Mexican Border War veterans
- Veterans solely seeking care for disorders associated with:
 - exposure to herbicides while serving in Vietnam; or
 - exposure to ionizing radiation during atmospheric testing or during the occupation of Hiroshima and Nagasaki; or
 - for disorders associated with service in the Gulf War;
 - for any illness associated with service in combat in a war after the Gulf War or during a period of hostility after November 11, 1998; or
 - Compensable 0% service-connected veterans

Priority Group 7

- Veterans who agree to pay specified copayments with income and/or net worth above the VA means test threshold and income below the HUD geographic index
 - *Sub-priority a:* Non-compensable 0% service-connected veterans who were enrolled in the VA Health Care System on a specified date and who have remained enrolled since that date

- *Sub-priority c*: Non-service-connected veterans who were enrolled in the VA Health Care System on a specified date and who have remained enrolled since that date
- *Sub-priority e*: Non-compensable 0% service-connected veterans not included in Sub-priority a above
- *Sub-priority g*: Non-service-connected veterans not included in Sub-priority c above

Priority Group 8

- Veterans who agree to pay specified copayments with income and/or net worth above the VA means test threshold and the HUD geographic index
 - *Sub-priority a*: Non-compensable 0% service-connected veterans enrolled as of January 14, 2003 and who have remained enrolled since that date
 - *Sub-priority c*: Non-service-connected veterans enrolled as of January 14, 2003 and who have remained enrolled since that date
 - *Sub-priority e*: Non-compensable 0% service-connected veterans applying for enrollment after January 14, 2003
 - *Sub-priority g*: Non-service-connected veterans applying for enrollment after January 14, 2003

Additional Information

The term “service-connected” means, with respect to a condition or disability, that VA has determined that the condition or disability was incurred in or aggravated by military service.

Which Veterans Pay for Which Services at VA Healthcare Facilities

	<i>Copayments</i>			Insurance Billing	Insurance Balanced Billing	Insurance Deductible/ Copayment
	Inpatient	Outpatient	Medication*			
Priority Group 1	No	No	No	Yes—if care was for NSC condition	No	No
Priority Groups 2, 3**, 4***	No	No	Yes—If less than 50% SC & medication is for NSC condition	Yes—if care was for NSC condition	No	No
Priority Group 5	No	No	Yes	Yes—if care was for NSC condition	No	No
Priority Group 6 (WWI, Mexican Border & 0% SC Compensable)	No	No	Yes	Yes—if care was for NSC condition	No	No
Priority Group 6 (Veterans receiving care for exposure or experience****)	No****	No****	No****	Yes—if care was for NSC condition	No	No
Priority Group 7	Yes	Yes	Yes	Yes—if care was for NSC condition	No	No
Priority Group 8	Yes	Yes	Yes	Yes—if care was for NSC condition	No	No

* An annual medication copayment cap has been established for veterans enrolled in priority groups 2-6. Medications will continue to be dispensed when the copayment cap is met. An annual medication copayment cap was not established for veterans enrolled in priority group 7.

** Veterans in receipt of a Purple Heart are in Priority Group 3. This change occurred with the enactment of PL 106-117 on November 30, 1999.

*** Priority Group 7 veterans who are determined to be Catastrophically Disabled and who are placed in Priority Group 4 for treatment are still subject to the copayment requirements as a Priority Group 7 veteran.

**** Priority Group 6—Health insurance and all applicable copayments will be billed when the care is for conditions not related to the veteran's exposure or experience.

Special Categories of Veterans—(i.e., Agent Orange, Ionizing Radiation, Persian Gulf, women veterans receiving military sexual trauma counseling) are subject to means test copayments when the treatment is not related to their exposure or experience. The initial registry examination and follow-up visits to receive results of the examination are not billed to the health insurance carrier. However, care provided not related to exposure, if it is non-service-connected will be billed to the insurance carrier.

Medication Copayment Exemption—All veterans receiving prescriptions for NSC conditions who meet the low income criteria are exempt from the medication copayment.

Priority Group 7 Veterans—For Inpatient Copayments Only. Veterans enrolled in this priority group are responsible for 20% of the inpatient copayment and 20% of the inpatient per diem copayment. The geographic means test copayment reduction does not apply to outpatient and medication copayments and veterans will be assessed the full applicable copayment charges.

Priority Group 8 Veterans—For Inpatient Copayments Only. Veterans enrolled in this priority group are responsible for the full inpatient copayment and the inpatient per diem copayment. Veterans in this priority group are also responsible for outpatient and medication copayments.

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